COVINGTON INDEPENDENT PUBLIC SCHOOLS
HEALTH SERVICES MEDICAL INFORMATION FORM

In order to assure the best care for your child, please provide the following information.

Child's name: _____ Date of Birth: _____

Parent/Guardian: _____Phone No._____

Emergency Contact: _____Phone No: _____

Physician Name: _____Phone No.:_____

Does your child have any allergies? □ Yes □ No List: __
Type of Reaction: _____

Does your child have asthma? □ Yes □ No Triggers: ___
*Medication :*_____

Does your child have a history of seizures? □ Yes □ No Type: _____
*Date of last seizure:*_____ *Medication:*_____

Please describe any other medical conditions: __
_____

Please list all medications your child takes on a regular basis: _____
_____

Will this child be taking any medications at school? □ Yes □ No
If yes, please list _____

Does your child's health condition require any special considerations at school? ☐ Yes ☐ No
If yes, please list:_____

Has your physician provided in writing that your child needs special accommodations in school?
☐ Yes ☐ No If yes, please provide a copy to school.

This information will be released to all of the following school personnel on a need to know basis:
* Bus Driver * Classroom Teachers * Counselor * Principal * Asst. Principal
* Speech/OT/PT/ School Psychologist * Family Resource Center/ Youth Service Center
Please indicate if you do not want this information shared with school personnel.

I hereby authorize release of any needed information to and from the above named physician and emergency contacts.

I give permission for my child named above to be taken by school personnel or ambulance for treatment in the case of an accident or sudden illness when I or the emergency contact listed above cannot be reached.

Parent/Guardian Signature: _____Date:_____