Emergency Medical Information and Treatment
(Please Print)

Child's Name: _____ Age: _____ Grade Entering: _____
[first] [middle] [last]

Person completing this survey: ____Mother ____ Father ____Grandparent ____Other: _____

Does your child have any allergies to medications, food or the environment? YES NO (circle one)

If yes, list and describe symptoms: _____

_____

Does your child take any medications daily? YES NO (circle one)

If yes, list and describe symptoms: _____

_____

Does your child have any medications they take as needed? YES NO (circle one)

If yes, list and describe _____

_____

All medications must be kept with and administered by the school Health Coordinator/Nurse with a parental note and written doctor's orders. No child will be allowed to carry or administer his/her own medication. **A copy of a physical exam completed within the past year must be kept on record at the school health office.**

Doctor: _____ Phone: _____

Address: _____

Preferred Hospital: _____

Is your child covered by medical insurance? YES NO (circle one)

If yes, please list insurance carrier: _____ Policy #:_____

I give my permission for the school nurse to share this information with my child's teacher. I give my permission for the school nurse to discuss this information with my child's doctor.

Guardian Name: _____ Guardian Signature:_____ Date:_____

Empowerment Academy Charter School

Annual Physical Exam Form

Please detach this from the packet and have completed by Physician or submit a Universal Health Form.
This must be turned in on the first day of school.

Student:_____ Date of Birth: _____Grade_____

Allergies:_____ Chronic Medical Conditions:_____

Blood Pressure:_____ Pulse:_____ Height_____ Weight:_____ BMI:_____

Screenings: Hearing_____ Vision_____ Lead_____ TB_____ Dental_____

Heart:_____ Orthopedic:_____ Speech:_____ Appearance:_____

Medications/Treatments:_____Limitations:_____

Limitations to Physical Activity:_____

Special Equipment needs:_____ Special Diet:_____

Behavioral Issues/Mental Health Diagnosis:_____

Emergency Plans that might be needed:_____

Immunizations: Record attached ____yes ____no, Date of next Immunization due:_____

Results of Physical Examination normal? _____yes _____no **Kindergarten students MUST attach record**

Abnormalities Noted:_____

Comments:_____

Date of Exam:_____

Physicians' Signature: _____

Please place stamp in this box: