Willowglen School

Westoak Trails Montessori Campus

MEDICAL INFORMATION

Student Name: _____

Gender: _____ Birth Date: Year ____ Month ____ Day ___

Allergies _____

Are these allergies severe enough that he/she is considered anaphylactic? Yes/No _____

Is it necessary to keep medication at school? _____
If yes, please state medication and complete a permission to administer medication form. _____

Has your child ever had any serious illnesses? _____
If yes, please provide details _____

Does your child have any special requirements for diet, rest or exercise? Yes/No _____
If yes, please provide details.
Diet: _____

Rest: _____

Exercise: _____

Has your child's eyes been tested? Yes/No _____ Results _____
Has your child's hearing been tested? Yes/No _____ Results _____

Name of Physician _____ Phone _____

Address _____ City _____

Emergency contact if parents cannot be reached:

Name _____ Relationship _____

Address _____ Home Phone: _____ Work _____ Cell _____

Parents' Consent Form:

In case of emergency resulting from an accident or illness where prompt medical attention is deemed necessary, and the parents cannot be immediately contacted, I hereby give my permission to take the above mentioned child to the nearest medical facility and to proceed with medical treatment. I understand that any medical expenses incurred for such treatment are my responsibility.

Date_____ Signature of Parent of Guardian _____