MINOR MEDICAL INFORMATION

Please Note: In order for your registration to be processed, you must return this completed form. The phone numbers included will be used to contact you before classes begin. You must notify us if any of this information changes.

Student's Name_____Male_____ Female_____

Parent's Name(s)_____

Mailing Address_____

_____

Phone Numbers (Home)_____(Work)_____

(Mother's Cell)_____(Father's Cell)_____

Birth Date: _____ Age _____

Health Information

1. Please list and describe allergies or reactions to:
   Medicines:
   Foods:
   Insect Stings:
   Recommended treatment for allergy:
   (Medication and authorization form must be supplied to the office.)

2. Does your child have asthma that has been diagnosed by a doctor?
   If yes, what treatment has been prescribed?
   (Medication and authorization form must be supplied to office.)

3. Please list and describe any chronic or severe illnesses, injuries, or surgeries:

4. Does your child have any need for special attention because of health problems?
   If yes, explain:

5. Does your child use vision or hearing aids?
   If yes, explain:

6. Does your child have any disabilities?
   If yes, explain:

7. Has your child ever had a seizure?
   If yes, explain:

8. Does your child currently take any prescription or non-prescription medications, pills (other than vitamins), or use an inhaler?
   If yes, please list:

Does it need to be given at school?
(Medication and form must be supplied to office.)

Child's Physician _____ Phone Number_____

In case of serious accident or illness, I authorize T.S.F.C. to send my child to an emergency facility at my expense.

Parent/Guardian Signature: _____Date_____