Princeton ISD Child Medical History Form

(To be completed by Parent or Guardian)

Student Name_____Grade:_____ Today's Date: _____

Please complete the following confidential information to be shared with teaching staff.

1. Does your child have asthma as diagnosed by a physician? _____Has your child had any allergic reactions to medications, foods, or insects? If yes, please list care required _____

_____

2. Has your child been diagnosed hyperactive by your physician? _____

If yes, please list _____

(medication, amount, and time of administration)

3. Does your child have a seizure disorder as diagnosed by a physician? _____

If yes, please list _____

(medication, amount, and time of administration)

4. Is this child taking any medication? _____ Name of medication and dosage _____

_____

5. Does your child have a hearing loss diagnosed by a physician? _____ Does he/she wear hearing aids? _____

Do you have any concerns regarding a hearing problem? _____

6. Does your child wear glasses _____, or contacts_____? If so, is the correction for near vision difficulties _____

or distance vision difficulties? _____

7. Doctor_____ Hospital_____

8. Please list other health concerns you have for your child. _____

_____

Authorization to Secure Emergency Medical Treatment of Minor Student

Student Name_____ Date: _____

I, the undersigned, do hereby authorize officials of the Princeton Independent School District to contact directly persons named as emergency contacts on the enrollment form, and do authorize the named physicians to render such treatment may be deemed necessary in their judgment, for the health of the aforesaid child.

I will not hold the school district financially responsible for the emergency care and/or transportation for said child.

Signature of Parent or Guardian: _____