Divine Redeemer Lutheran School
Parent Completed Medical Information Form

Student Name: _____ Date of Birth: _____

Life Threatening Allergic Conditions: (check all that apply)

- ☐ Severe allergic reaction to bee stings, other insects: _____
- ☐ Severe reaction to nuts, peanuts: _____
- ☐ Severe reactions to other food products: _____
- ☐ Other severe allergies affecting school: _____

Please indicate any of your child's symptoms which would indicate a severe allergy:

- ☐ Itching and/or tightness in the throat, hoarseness
- ☐ Shortness of breath, coughing, and/or wheezing
- ☐ Hives
- ☐ Itching or swelling of the eyes, lips, tongue or mouth
- ☐ Thready pulse, passing out or loss of consciousness

Has your physician prescribed an EpiPen or other medicine for a severe life threatening allergy?

☐ Yes ☐ No Name of Medication: _____

Health Conditions: Has your child been diagnosed by a physician with any of the following? Check "yes" or "no" and provide dates and details for all items checked "yes".

Yes	No	Condition	Details/Dates
☐	☐	ADD or ADHD (Please circle type)	
☐	☐	ADD or ADHD (Taking Medication)	
☐	☐	Allergies to medication	
☐	☐	Allergies to environment or seasonal	
☐	☐	Asthma/Reactive Airway	
☐	☐	Behavior problems	
☐	☐	Bowel or digestive problems	
☐	☐	Diabetes: Insulin Dependent Yes/No	
☐	☐	Emotional disorder	
☐	☐	Hearing loss	
☐	☐	Heart problem	
☐	☐	Immunodeficiency disease	
☐	☐	Kidney or urinary problems	
☐	☐	Migraine headaches	
☐	☐	Orthopedic problems (bone, joint)	
☐	☐	Seizure Disorder, Type?	
☐	☐	Surgeries/hospitalizations	
☐	☐	Vision problems	
		Wears Glasses: Yes/No	
		Wears Contacts: Yes/No	

List of current medications (include prescription and over the counter):

_____

_____

_____

Special Needs:

Are there any other medical diagnoses or disabling conditions that might require a modification in your child's activities at school?

☐ Yes ☐ No If yes, please specify: _____

Parent/Guardian Signature: _____ Date: _____