Montrose Community Schools

300 Nanita Drive ~ P.O. Box 3129
Montrose, MI 48457
Phone: 810.639.6131 ext 8800 OR 810.591.8800
Fax: 810.591.7268

MEDICAL CONDITIONS / HISTORY

STUDENT NAME: _____ SCHOOL YEAR: _____

ALLERGIES (PLEASE INDICATE IF YOUR CHILD HAS ANY ALLERGIES BELOW)

- ☐ BEE STING
- ☐ LATEX
- ☐ FOOD _____
- ☐ MEDICATION _____
- ☐ ANIMAL _____
- ☐ OTHER _____

If exposed to the above allergen, does your child take medication? (Ex. Benadryl, Epi-pen) _____

ASTHMA

Has your child been diagnosed with asthma? _____
Please list current asthma medications: _____
Where does your child keep his/her inhaler? (Please indicate below)

	OFFICE		SELF-CARRY
	NO SCHOOL INHALER		OTHER

MEDICAL CONDITIONS (Please indicate if your child has any medical conditions) ***Physician documentation may be required***

	BLADDER PROBLEMS		HYPERTENSION (high blood pressure)
	BLEEDING DISORDER		HYPOGLYCEMIA
	BOWEL PROBLEMS		LACTOSE INTOLERANCE
	CYSTIC FIBROSIS		MIGRAINE HEADACHES
	DIABETES		NOSEBLEEDS (FREQUENT ONLY)
	ECZEMA		SEIZURES
	HEART CONDITIONS		TOURETTE SYNDROME
	OTHER		MEDICAL DEVICE (BRACE, GLASSES/CONTACTS, HEARING AIDE)
	RESTRICTIONS		

Please List Current Medications	Reason for Medication (optional)
Will the school be responsible for administering prescription medication to your child? (please circle)	YES NO
If YES, please indicate medications and dosage instructions:	
*Parents must fill out a **Permission Form for Prescription and Non-Prescription Medication form** prior to any medication (prescription and over-the-counter) administered by school personnel. These forms are available in the school office and on our website*	

In the event of an accident or serious illness, I request the school to contact me. If the school is unable to reach myself or emergency contacts, the school may make whatever arrangements deemed necessary, and I will accept financial responsibility.

Physician Name: _____Phone: _____
Preferred Hospital: _____

Parent/Guardian Signature: _____ Date: _____