

Lynd Public School Medical Health Form

Please fill out this form and return to school

Student's Name _____ Birthdate _____ Grade _____

Father's Name _____ Address _____

Phone: Home _____ Work _____

Mother's Name _____ Address _____

Phone: Home _____ Work _____

In case of an emergency, may we have permission to take your child to the office of either a doctor or dentist of emergency care? Yes _____ No _____

Please circle which hospital you wish to have your child taken to for emergency care:

Tyler _____ Marshall _____ Other _____

Emergency contact person and phone # in case either parent/guardian cannot be reached:

Phone _____

Phone _____

Medical History – To be completed by parent or guardian.

Has your child ever had any complications of or treatment for any of the following conditions?

Vision Problems: Glasses _____ Contacts _____ Date of last exam _____

Hearing Problems: P.E. Tubes _____ Date _____ History of ear infections _____

Surgery: Type: _____ Date _____

Orthopedic: (fractures, ect.) _____ Date _____

Neurological: (seizures?) _____ Date _____

Infections: Mononucleosis _____ Date _____ Strep Throat _____ Date _____

Diabetes: Insulin _____ Dosage _____ Type of Blood Sugar Testing _____

Allergies: Specify _____ Medication used _____

Asthma: Medication used _____ Date of last exam _____

Other medical problems we should be aware of: _____

Is this student on any medications at this time? _____

Has this student had any additional immunizations, other than what is required or completed?

Type _____ Date _____

It is the Minnesota State Law that no prescription or over the counter medications be given in school without signed orders from the student's physician and parent or guardian. All medications must be turned in to the office. All prescription and over the counter medications must be in the original container.

Parent/Guardian Signature _____ Date _____