

2026-2027

Medical Information Form

Student _____
Last First Middle

Student ID# _____ Grade: _____ Birth Date _____ / _____ / _____ Gender: M / F
MM/DD/YYYY

Primary Parent/Guardian Name: _____

Primary Parent/Guardian Cell Phone Number: () (-) Email: _____

Primary Parent/Guardian Email Address: _____

Address: _____
Street City/State Zip

Please circle any conditions that apply to your child.

- | | | |
|------------------------------|-----------------------------------|----------------------------|
| 1. Asthma/breathing problems | 7. Cancer | 13. Heart problems |
| 2. ADHD | 8. Cystic fibrosis | 14. Kidney problems |
| 3. Bladder problems | 9. Dental (tooth) problems/braces | 15. Mental health problems |
| 4. Bleeding problems | 10. Diabetes | 16. Nosebleeds (frequent) |
| 5. Bone/joint problems | 11. Epilepsy/seizures | 17. Sickle cell disease |
| 6. Bowel problems | 12. Headaches (severe) | |

Please explain any circled items or other serious surgeries, illnesses, or injuries: _____

In your opinion, might any of the problems circled above or any other medical condition your child has affect his/her school performance, program, or ability to participate in a regular physical education program? Yes _____ No _____

If yes, please explain: _____

Please list allergies, describe reactions, indicate severity, and any medications for allergic reactions:

	Allergic To	Reaction (rash, shortness of breath, etc.)	Severity (mild, severe, life-threatening)	Medication Needed
Insect stings/bites				
Food/Plants				
Medicines				
Other				

Has your child been diagnosed with asthma by a doctor? Yes _____ No _____

If yes, what treatment has been prescribed? _____ Inhaler _____ Nebulizer _____ Other, please list: _____

Does your child need to take any medications (prescription or over-the-counter) or require any medical treatment at school?
Yes _____ No _____

If yes, please list: _____

If yes, parent must provide a new Authorization for Medication form each school year. All medications must be brought to school by an adult.

I understand and agree that certain educational records of my child may be shared with Florida Southern College's health care partners as needed to provide and evaluate health services to students. I also understand and agree that my child's medical treatment records created by healthcare personnel at school may be shared with school officials who have a legitimate educational purpose for accessing such records. I understand that it is my responsibility to notify the school of any changes in the information recorded on this form.

Primary Parent/Guardian Signature

Primary Parent/Guardian Name Printed

Date