

FORT BEND I.S.D. MEDICAL INFORMATION CERTIFICATE



PLEASE PRINT

Student's Name: _____ Campus: _____
Last First Middle

Age: _____ Date of Birth: ____/____/____ Grade: _____ Sex: M F Student ID #: _____
(Circle One)

Address: _____
Street City State Zip Code

Subdivision: _____ Home Phone Number: (____) ____-____

Name of Physician: _____ Physician's Telephone: (____) ____-____

Medical Health Insurance Coverage: YES / NO If YES, What Type: HMO / PPO / OTHER

Insurance Company: _____ Policy Number: _____ Group: _____

Emergency Contact – Parent(s)/Guardian(s): _____

Father's Work Phone: (____) ____-____ Father's Cell Phone: (____) ____-____

Father's Place of Employment: _____

Mother's Work Phone: (____) ____-____ Mother's Cell Phone: (____) ____-____

Mother's Place of Employment: _____

E-mail: Father _____ Mother _____

Medical History:

	Yes	No		Yes	No
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Allergy to medication	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease and/or injury	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding tendencies	<input type="checkbox"/>	<input type="checkbox"/>	Neck injury	<input type="checkbox"/>	<input type="checkbox"/>
Bone and/or joint injury or disease	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Contact Lenses/Glasses	<input type="checkbox"/>	<input type="checkbox"/>	Seizures, concussion, loss of consciousness	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Eye, Kidney, Lung removed/nonfunctioning	<input type="checkbox"/>	<input type="checkbox"/>	Skin Disease	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Surgical operation	<input type="checkbox"/>	<input type="checkbox"/>
Hernia	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Is student taking medication regularly?	<input type="checkbox"/>	<input type="checkbox"/>	Is student currently under a physician's care?	<input type="checkbox"/>	<input type="checkbox"/>

Date of last tetanus shot? _____

Explain any "yes" answers, please explain: _____

Please list **all** medications and any illnesses not listed above requiring medication being taken at the present time. _____

I hereby consent for medical care to be given to _____ in case of an emergency.

Signature of Parent/Guardian

Date

Please return this form to your child's teacher of record.

This form must accompany the student on all school trips.