CONFIDENTIAL MEDICAL INFORMATION/SPECIAL ATTENTION FORM

Student Name_____ **D.O.B.**_____

Please explain conditions that apply:

Diagnosis	Explanation/Treatment
Allergies ☐ No ☐ Yes	
Asthma ☐ No ☐ Yes	
Diabetes ☐ No ☐ Yes	
Seizures ☐ No ☐ Yes	
Heart Problems ☐ No ☐ Yes	
Recurring Illness ☐ No ☐ Yes	
Other Condition(s) ☐ No ☐ Yes	
Difficulty or Diagnosis that may affect learning	
List of Medications	

Physician's Name_____Phone #_____

Dentist's Name_____Phone #_____

Hospital Preference_____

In case of accident or serious illness, and parent(s) or emergency contact(s) cannot be reached, I hereby authorize the school to contact the child's physician and/or summon emergency care as deemed necessary.

Parent/Guardian Signature_____

Print Name_____Date_____