

FORT BEND I.S.D. MEDICAL INFORMATION CERTIFICATE

PLEASE PRINT

Student's Name _____ Sex M F Age _____
Last First Middle (Circle one)

Parent's Name _____ Student's Date of Birth _____

Parent's Home Telephone _____ Parent's Work Telephone _____

Mother's Cell Phone _____ Father's Cell Phone _____

Address _____
Street City State Zip Code
 Subdivision _____

Emergency Telephone and Contact's Name

School _____ Grade _____ Telephone _____

Insurance Company _____ Policy Number _____

TO BE COMPLETED BY PARENT OR GUARDIAN

Name of Physician _____ Physician's Telephone _____

Does the student have previous history of:

	Yes	No		Yes	No
Bleeding tendencies	<input type="checkbox"/>	<input type="checkbox"/>	Now under a physician's care?	<input type="checkbox"/>	<input type="checkbox"/>
Head injuries, seizures unconsciousness, concussion or convulsion	<input type="checkbox"/>	<input type="checkbox"/>	Date of last tetanus shot? _____	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Allergy	<input type="checkbox"/>	<input type="checkbox"/>
Hernia	<input type="checkbox"/>	<input type="checkbox"/>	Neck injury	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Bone and/or joint injury or disease	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
Sickle Cell Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease and/or injury	<input type="checkbox"/>	<input type="checkbox"/>			
Kidney, Lung, or Eye removed or nonfunctioning	<input type="checkbox"/>	<input type="checkbox"/>	Surgical operation	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Allergy to medication	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Contact Lenses/Glasses	<input type="checkbox"/>	<input type="checkbox"/>
Skin Disease	<input type="checkbox"/>	<input type="checkbox"/>			
Is student taking medication regularly?	<input type="checkbox"/>	<input type="checkbox"/>			

Explain any "yes" answers _____

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.

Parent/Guardian Signature