|  |  |
| --- | --- |
| SAMPLE:  INSERT LOGO/SAU/SCHOOL NAME | ANNUAL MEDICAL FORM  SCHOOL YEAR \_\_\_\_\_\_ |

|  |  |
| --- | --- |
| **Student**  Date of Birth Grade | Parent/Guardian Phone  Parent/Guardian Phone  Emergency Phone |
| Address   * Unaccompanied youth |
| Physician  Phone Last visit | Dentist  Phone Last visit |
| Life Threatening Allergies: | |
| Emergency medication | Last event |

Indicate if your child has any of the following:

|  |  |
| --- | --- |
| * Epilepsy or seizures   [Seizure Interview Form](https://www.maine.gov/doe/sites/maine.gov.doe/files/inline-files/School%20Health%20Services%20-%20Sample%20Seizure%20Interview%20%5BEnglish%5D%20-%208.21.2024.docx) | * Diabetes   [Diabetes Interview Form](https://www.maine.gov/doe/sites/maine.gov.doe/files/inline-files/School%20Health%20Services%20-%20Sample%20Diabetes%20Interview%20%5BEnglish%5D%20-%208.21.2024.docx) |
| * Asthma or lung condition   [Asthma Interview Form](https://www.maine.gov/doe/sites/maine.gov.doe/files/inline-files/School%20Health%20Services%20-%20Sample%20Seizure%20Interview%20%5BEnglish%5D%20-%208.21.2024.docx) | * Cardiovascular condition |
| * Sickle cell * Hemophilia * Other blood disorder | * Surgery/hospitalization/trauma history |
| * Mental health condition | * Other |

Please list all medications that your child takes at home.

|  |  |  |
| --- | --- | --- |
| Medication | Strength, Dose, Route | Time of Day |
|  |  |  |
|  |  |  |
|  |  |  |

If your child needs medication during the school day, complete this form:

[Medication Authorization Form](https://www.maine.gov/doe/sites/maine.gov.doe/files/inline-files/School%20Health%20Services%20-%20Sample%20Medication%20Authorization%20%5BEnglish%5D%20-%208.21.2024.docx)

If you need assistance with any of the following, the school nurses can provide resources to assist your family

|  |  |
| --- | --- |
| * Obtaining health insurance * Finding a medical, dental, or mental health provider | * Housing * Clothing * Food |

By signing below, I permit the school nurse to share information about my student’s health with appropriate school and medical personnel for my student’s ongoing safety at school.

Parent/Gaurdian\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_