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

|  |  |
| --- | --- |
| **Student**Date of Birth Grade | Parent/Guardian PhoneParent/Guardian PhoneEmergency Phone |
| Address* Unaccompanied youth
 |
| PhysicianPhone Last visit | DentistPhone 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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_