Livingston EDUCATIONAL SERVICE Agency

MEDICAL INFORMATION

Student Name: _____ Date of Birth: _____

Doctor's Name: _____ Doctor's Phone Number: _____

Medical Diagnosis *(Cerebral Palsy, Hydrocephalus, Down Syndrome, other)*:

_____

Surgical History *(Myringotomy, Shunts, Heart, Fundoplication, Orthopedic, other)*:

_____

Allergies:	Type	Reaction	Intervention
Foods			
Insects			
Medications			
Other			

Medical Condition(s):

Contact Lenses	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No
Glasses	☐ Yes	☐ No	Respiratory Condition	☐ Yes	☐ No
Hearing Aid(s)	☐ Yes	☐ No	Tracheostomy	☐ Yes	☐ No
Hearing Impairment	☐ Yes	☐ No	Ventricular Shunt	☐ Yes	☐ No
Heart Condition	☐ Yes	☐ No	Visual Impairment	☐ Yes	☐ No
Oxygen	☐ Yes	☐ No	Rate, Mask, etc. _____		

Bowel or Bladder status *(Catheterization, Ostomy, Incontinence, Constipation, Diarrhea, other)*:

_____

Known deformities *(Scoliosis, Paralysis, one Kidney, other)*:

_____

Does your child have a history of seizures? ☐ Yes ☐ No Frequency: _____

If Yes, please describe progression of, and/or, events:

_____

Does your child have unusual behaviors? ☐ Yes ☐ No If Yes, please describe the behavior:

_____

Is your child have an emotional or psychological impairment? ☐ Yes ☐ No If Yes, please explain:

_____

Medication Information: List ALL medications given to your child *(at school **and** at home)*:

Type	**Dosage**	**Time of Day Dispensed**

If additional space is needed, please attach as necessary.

All medication MUST be given to the bus driver, by the parent. Students should not personally carry any medication. The school nurse must have a copy of all medication prescriptions.

A COPY OF YOUR CHILD'S IMMUNIZATION (OR SIGNED WAIVER) MUST BE PROVIDED PRIOR TO HIM/HER BEING PERMITTED TO START SCHOOL.