FORT BEND I.S.D. MEDICAL INFORMATION CERTIFICATE

PLEASE PRINT

Student's Name: _____ Campus: _____
Last First Middle

Age: _____ Date of Birth: _____/_____/_____ Grade: _____ Sex: M◯ F◯ Student ID #: _____

Address: _____
Street City State Zip Code

Subdivision: _____ Home Phone Number: (_____) _____-_____

Name of Physician: _____ **Physician's Telephone: (_____) _____-_____**

Medical Health Insurance Coverage: YES◯ NO◯ If YES, What Type: HMO◯ PPO◯ OTHER◯

Insurance Company: _____ Policy Number: _____ Group: _____

Emergency Contact – Parent(s)/Guardian(s): _____

Father's Work Phone: (_____) _____-_____ Father's Cell Phone: (_____) _____-_____

Father's Place of Employment: _____

Mother's Work Phone: (_____) _____-_____ Mother's Cell Phone: (_____) _____-_____

Mother's Place of Employment: _____

E-mail: Father _____ Mother _____

Medical History:

	Yes	No		Yes	No
Allergies	☐	☐	High Blood Pressure	☐	☐
Allergy to medication	☐	☐	Hepatitis	☐	☐
Asthma	☐	☐	Kidney Disease and/or injury	☐	☐
Bleeding tendencies	☐	☐	Neck injury	☐	☐
Bone and/or joint injury or disease	☐	☐	Rheumatic Fever	☐	☐
Contact Lenses/Glasses	☐	☐	Seizures, concussion, loss of consciousness	☐	☐
Diabetes	☐	☐	Sickle Cell Anemia	☐	☐
Eye, Kidney, Lung removed/nonfunctioning	☐	☐	Skin Disease	☐	☐
Heart Disease	☐	☐	Surgical operation	☐	☐
Hernia	☐	☐	Tuberculosis	☐	☐
Is student taking medication regularly?	☐	☐	Is student currently under a physician's care?	☐	☐

Date of last tetanus shot? _____

Explain any "yes" answers, please explain: _____

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.

_____ _____
Signature of Parent/Guardian **Date**

Please return this form to your child's teacher of record. ***This form must accompany the student on all school trips.***