FORT BEND I.S.D. MEDICAL INFORMATION CERTIFICATE

PLEASE PRINT

Student's Name_____
Last First Middle Initial

Parent's Name_____ Student's Date of Birth_____

Parent's Home Telephone_____ Parent's Work Telephone_____

Address_____
Street City State Zip Code

Emergency Telephone and Contact's Name _____

Telephone #_____

TO BE COMPLETED BY PARENT OR GUARDIAN

Name of Physician_____ **Physician's Telephone**_____

Does the student have previous history of:

	Yes	No
Bleeding tendencies	☐	☐
Head injuries, seizures unconsciousness, concussion or convulsion	☐	☐
Asthma	☐	☐
Hernia	☐	☐
High Blood Pressure	☐	☐
Tuberculosis	☐	☐
Sickle Cell Anemia	☐	☐
Kidney Disease and/or injury	☐	☐
Kidney, Lung, or Eye removed or nonfunctioning	☐	☐
Hepatitis	☐	☐
Rheumatic Fever	☐	☐
Skin Disease	☐	☐
Is student taking medication regularly?	☐	☐

	Yes	No
Now under a physician's care?	☐	☐
Date of last tetanus shot?_____		
Allergy		
Neck injury	☐	☐
Bone and/or joint injury or disease	☐	☐
Heart Disease	☐	☐
Diabetes	☐	☐
Surgical operation	☐	☐
Allergy to medication	☐	☐
Contact Lenses/Glasses	☐	☐

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