



Please Print Legibly In Black Or Blue Ink

BT **MEDICAL INFORMATION**

MJ SECONDARY STUDENT

WS AM PM FD

Date _____ Lab _____ Grade _____ Home School _____

Name _____ Age _____ Birth Date _____ Sex _____

Address _____ Phone _____

Father's Name _____ Natural Step

Address _____ Phone _____

Father's Employer _____ Phone _____

Address _____ Phone _____

Mother's Name _____ Natural Step

Address _____ Phone _____

Mother's Employer _____ Phone _____

Address _____ Phone _____

Please check if Parents are Divorced Separated Student Lives With _____

IF PARENTS CANNOT BE REACHED, LIST 2 NEARBY RELATIVES OR PERSONS WHO WILL ASSUME CARE OF YOUR CHILD: RELATIVES PREFERRED

1. Name _____ Phone _____

Address _____

Relationship to Student _____

2. Name _____ Phone _____

Address _____

Relationship to Student _____

Physician of Choice _____ Phone _____

Name of Preferred Hospital _____

Student's Name _____

Student's Social Security Number _____

Please
circle

1. **YES or NO** • My child has the following allergies, such as bee-stings, Penicillin, medicines, etc.? (List what below):

2. **YES or NO** • My child requires special seating in the class? What type? _____
3. **YES or NO** • My child has the following physical conditions which may limit participation in their school program:

4. **YES or NO** • My child has had surgery, serious illness, or accident in the past year? Please list: _____
5. **YES or NO** • My child is taking medication? List medication & condition: _____

6. **YES or NO** • My child has the following conditions not listed above, such as epilepsy, migraines, etc. Please list:

7. **YES or NO** • Eyeglasses or Contacts? Please specify: _____
8. **YES or NO** • Hearing difficulties (Left Ear)? _____ (Right Ear)? _____
9. **YES or NO** • My child has had a **tetanus shot**. Date of immunization: _____

CONSENT OF AUTHORIZATION

I consent to allow _____ to receive emergency first aid at the CTC Center in event of sudden illness or accident. If his/her condition should require treatment by a doctor and none of the persons listed on the front can be reached I further give my permission for him/ her to be transported by an ambulance or responsible person to the hospital or physicians office. I will assume necessary expense if any.

PARENT OR GUARDIAN SIGNATURE _____ DATE _____

I also give my consent for _____ to receive the following if needed.

Generic Tylenol Generic Advil Antacid Throat Lozenges

PARENT OR GUARDIAN SIGNATURE _____ DATE _____

PLEASE COMPLETE.

SIGN & RETURN IMMEDIATELY