The Calais School

MEDICAL INFORMATION SHEET
2024-2025

STUDENT_____ D.O.B._____

FAMILY DOCTOR_____ OFFICE PHONE_____

ADDRESS_____

FAMILY DENTIST_____ OFFICE PHONE_____

ADDRESS_____

SPECIALISTS

NAME_____ OFFICE PHONE_____

ADDRESS_____

HEALTH INFORMATION

Does your student have any chronic health conditions? YES____ NO____

If yes, please indicate:

___Asthma	___Bee Sting Allergy	___Internal Irregularities
___Kidney/Bladder	___Anaphylaxis	___Convulsive Seizures
___Arthritis	___Other Allergy (list):	___Sight Impairment
___Diabetes	_____	___Wears Glasses
___Type 1 ___Type 2	_____	___Deafness
___Heart		___Surgical
___Bleeding Disorders		___Fractures

Please explain ALL if yes:_____

PRESCRIPTION MEDICATION: Name and dosage:_____

_____

Time administered: At Home: _____ At School:_____

NON-PRESCRIPTION MEDICATION: Name and dosage:_____

_____

Time administered: At Home: _____ At School:_____

SPECIAL DIETARY RESTRICTIONS OR ADDITIONAL REQUESTS _____

_____

_____

_____ _____

Signature of Parent/Guardian Date