ROWLAND HALL-ST. MARK'S SCHOOL

Student Medical Data

NAME OF STUDENT_____

ADDRESS_____

AGE_____ DATE OF BIRTH_____ PHONE_____

Does your child have any severe medical problems (asthma, allergy to drugs, heart trouble, epilepsy, diabetes, physical handicaps or dietary restrictions)? If yes, describe. yes no

Is he/she taking any medication?
List names, amount, why taken, and any side effects:

Should there be any limits on physical activity? yes no

Has he/she been seriously ill in the last 3 years? yes no

At the present time, is he/she under a doctor's care? yes no

May we contact the doctor for medical reports? yes no

Doctor's Name_____Phone_____

Is the student covered by medical insurance? yes no

Company Name_____Insurance #_____

Date of last complete physical examination?_____

Date of last Tetanus Toxoid injection?_____

If your child is below the legal age of consent (18 years), the law requires that we have your permission to give medical service should the need arise. Please, read carefully and sign below:

I authorize medical examination and treatment as may be deemed advisable by the physician or staff member in attendance. For major illnesses or injuries, an attempt to contact me before institution of treatment will be made, unless such treatment is so urgent it must be done before contact can be made. If I cannot be reached, I authorize the attending physician to act as medical judgment may dictate. I also agree to assume any financial responsibility for his/her care.

THIS CONSENT SHALL BE IN EFFECT FROM_____TO_____,

PARENT/GUARDIAN'S SIGNATURE_____

PARENT/GUARDIAN'S NAME PRINTED_____

PARENT/GUARDIAN'S PHONE (HOME)_____(WORK)_____

In case of emergency, person to contact if parent/guardian cannot be reached:

_____Phone:_____