Student Medical Information

Circle all that apply

FRESHMAN TRANSFER NON-ATHLETE ATHLETE

Student's Full Name: _____ Year of Graduation: _____

Date of Birth: _____

Student Medical History

Must be completed by parent/guardian. Please circle yes or no. Include details for each **YES** answer.

1. Previous hospitalization? YES NO DETAILS _____
2. Heart difficulties? YES NO DETAILS _____
3. Previous disease? YES NO DETAILS _____
4. Surgery? YES NO DETAILS _____
5. Handicaps? YES NO DETAILS _____
6. Convulsions/seizures? YES NO DETAILS _____
7. Breathing difficulties or asthma? YES NO DETAILS _____
8. Diabetic? YES NO DETAILS _____
9. Allergies? YES NO DETAILS _____
10. Vision problems? YES NO DETAILS _____
11. Hearing problems? YES NO DETAILS _____
12. Learning/educational disability? YES NO DETAILS _____
13. Prescription medication (continuing basis)? YES NO DETAILS _____
    _____
14. Alternative/ traditional medicine? YES NO DETAILS _____

When a student is taking a prescribed or non-prescribed medication at school, parents/guardians are to notify the Director of Student Safety and Discipline in writing. The student's medication must be stored in the attendance office and/or residential hall along with written instructions for usage. Inhalers may be carried by the student only with written verification from a physician.

Does your student have any physical conditions that would limit his/her participation in school-related activities (PE/ sports)? YES NO DETAILS _____

I agree that the above information is accurate and up-to-date. I give SJM permission to share this information with school personnel to protect the health and safety of my student. I understand that I am responsible for notifying the Administration in writing of any changes in the medical condition of my student.

Name of legal Parent/Guardian (printed): _____

Signature of legal Parent/Guardian: _____ Date: _____