## **Medical Update**

Parent Name	Student Nam	e		_ Date of Birth		
Primary Care Physician Address Phone Psychiatrist Address Phone Neurologist Address Phone  Neurologist Address Phone  Other Medical Specialists Address Phone  My child takes the following medications on a routine basis Medication Dose Times given Purpose  My child takes the following medications on an as needed basis Medication Dose Given under these circumstances  My child takes the following medications on an as needed basis Medication Dose Given under these circumstances  My child takes the following medications on an as needed basis Medication Dose Given under these circumstances  My child takes the following medications on an as needed basis Medication Frequency  Treatment Is child currently seizure activity (a seizure profile may be requested)  Type Frequency  Treatment Is child currently seizure active? Last known seizure Significant allergies Food allergies requiring special diet Food sensitivities  Medication allergies Environmental Other History of car infections PE Tubes currently in place (circle Right, Left, Both)  Asthma or chronic upper respiratory difficulties History of contagious illness - please specify Has had Chicken pox illness? Has had vaccine?  Glasses or corrective lenses - please specify when needed Hearing Aids Other medical condition/needs	Parent Name			Date of Report		
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