

**FORT BEND I.S.D. MEDICAL INFORMATION CERTIFICATE (Form 1)**

PLEASE PRINT

Student

Name \_\_\_\_\_ Sex M F Age \_\_\_\_\_  
Last First Middle (Circle One)

Parent's Name \_\_\_\_\_ Student's Date of Birth \_\_\_\_\_

Parent's Home Telephone \_\_\_\_\_ Parent's Work Telephone \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip Code

Subdivision \_\_\_\_\_

**Emergency Telephone and Contact's Name** \_\_\_\_\_

School \_\_\_\_\_ Grade \_\_\_\_\_ Telephone \_\_\_\_\_

Insurance Company \_\_\_\_\_ Policy Number \_\_\_\_\_

**TO BE COMPLETED BY PARENT OR GUARDIAN**

Name of Physician \_\_\_\_\_ Physician's Telephone \_\_\_\_\_

Does the student have previous history of:

	Yes	No		Yes	No
Bleeding Tendencies	<input type="checkbox"/>	<input type="checkbox"/>	Now under a physician's care?	<input type="checkbox"/>	<input type="checkbox"/>
Head injuries, seizures Unconsciousness, concussion	<input type="checkbox"/>	<input type="checkbox"/>			
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Date of last tetanus shot? _____		
Hernia	<input type="checkbox"/>	<input type="checkbox"/>	Allergy	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Neck Injury	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Bone and/or joint injury or disease	<input type="checkbox"/>	<input type="checkbox"/>
Sickle Cell Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease and/or injury	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Kidney, Lung, or Eye removed Or non-functioning	<input type="checkbox"/>	<input type="checkbox"/>			
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Surgical operation	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Allergy to Medication	<input type="checkbox"/>	<input type="checkbox"/>
Skin Disease	<input type="checkbox"/>	<input type="checkbox"/>	Contact Lenses/Glasses	<input type="checkbox"/>	<input type="checkbox"/>
Is student taking medication regularly?	<input type="checkbox"/>	<input type="checkbox"/>			

Explain any "yes" answers \_\_\_\_\_

Please list all medications and any illnesses not listed above requiring medication being taken at the present time.

**I hereby consent for medical care to be given to \_\_\_\_\_ in case of an emergency.**

\_\_\_\_\_  
**Parent/Guardian**