

Medical Record

Good Shepherd Lutheran School
East Troy, WI
Proclaiming the Gospel of Jesus Christ



Student Information

Student Name _____
Last First Middle Nickname

Mailing Address _____

Home Address _____
If different from mailing address

Mother _____
Name Address Phone

Father _____
Name Address Phone

Insurance Company _____ Policy number _____

Physician/Hospital/Dentist Information

Family Physician _____
Name Address Phone

Hospital Preference _____
Name Address Phone

Family Dentist _____
Name Address Phone

Allergies & Medications

Medication _____ Explanation _____

Food Allergies _____

Insect Bites _____

Other Allergies _____

Other Special Concerns _____

Significant Personal History of Student (check all that apply)

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Congenital Defect | <input type="checkbox"/> Mumps | <input type="checkbox"/> Kidney Disorder | <input type="checkbox"/> Bone and Joint |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Chicken Pox |
| <input type="checkbox"/> Vision Problems | <input type="checkbox"/> Heart Disorder | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Convulsions or Seizures |
| <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Asthma | <input type="checkbox"/> Poliomyelitis | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Frequent Colds | <input type="checkbox"/> Frequent Strep Infections |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Muscular Disorder | |

Other Conditions _____

If any preceding conditions are checked, please give special instructions for care _____

Significant Family Health History (Parents and Siblings)

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Kidney Disorder | <input type="checkbox"/> Nervous Disorder | <input type="checkbox"/> Mental Disorder |

Other (please specify) _____

I (We) hereby authorize:

- Release of above information to all Good Shepherd Lutheran School & Childcare Personnel and School Bus Drivers.
- The Principal or other School Personnel to call the Physician or Dentist names above if an emergency exists, or if it is necessary, an alternate doctor.
- Permission for transporting my child if in need of emergency care.

Medical Consent:

In the case of illness or accident requiring medical care, you have my (our) permission to obtain such care from the nearest hospital and to release personal identifiable information regarding my (our) child. I(We) agree to pay all expenses incurred in such emergency care.

Parent/Guardian Signature _____ Date _____

Parent/Guardian Signature _____ Date _____