FORT BEND I.S.D. MEDICAL INFORMATION CERTIFICATE

PLEASE PRINT

Student's 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	☐	☐	Now under a physician's care?	☐	☐
Head injuries, seizures unconsciousness, concussion or convulsion	☐	☐	Date of last tetanus shot?_____________________________		
Asthma	☐	☐	Allergy	☐	☐
Hernia	☐	☐	Neck injury	☐	☐
High Blood Pressure	☐	☐	Bone and/or joint injury or disease	☐	☐
Tuberculosis	☐	☐			
Sickle Cell Anemia	☐	☐	Heart Disease	☐	☐
Kidney Disease and/or injury	☐	☐	Diabetes	☐	☐
Kidney, Lung, or Eye removed or nonfunctioning	☐	☐			
Hepatitis	☐	☐	Surgical operation	☐	☐
Rheumatic Fever	☐	☐	Allergy to medication	☐	☐
Skin Disease	☐	☐	Contact Lenses/Glasses	☐	☐
Is student taking medication regularly?	☐	☐			

Explain any "yes" answers____
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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