

MILFORD SCHOOL HEALTH SERVICES

STUDENT MEDICAL RECORD UP-DATE

School: _____ Date: _____

Child's Name: _____ Date of Birth: _____

Parents/Guardians Name: _____ Home Phone: _____

Address: _____ Work Phone: _____

Primary Health Care Provider's Name _____ Telephone: _____

Choice of Hospital: _____

1. Please provide information about _____

Please include age at initial onset, date of diagnosis, current status, etc.: _____

Are there any other health concerns: _____

2. Are there any restrictions or conditions which would effect the child's performance, e.g. weather changes, exertion, stressful situations? _____

3. Name of medication (s) taken routinely or whenever needed.

Medication	Dose	How Often	Under What Circumstances

Note: It is important to notify the nurse and teacher if and when medication is given at home before school.

4. Does your child experience any side effects to these medications? If so, please list:

5. If your child does not respond as expected to medication, what action should be taken?

6. May we contact your child's primary health care provider if there is a question regarding this health condition? YES NO

7. Is there anything other than this information that you feel would be helpful in providing optimum health care for your child in school? _____

Thank you for your cooperation and help in this matter.

Parent Signature: _____ Date: _____