



GRADUATION YEAR _____

STUDENT NAME:

Last First Middle

SENDING SCHOOL: _____ SESSION: _____

PROGRAM: _____ MALE: [] FEMALE: []

ADDRESS: _____
Street City Zip

PHONE NUMBER: _____

PARENT EMAIL: _____ STUDENT EMAIL: _____

PHYSICIAN: _____ PHONE NUMBER: _____

DENTIST: _____ PHONE NUMBER: _____

In an emergency, 911 will be called and students will be transported to the nearest hospital.

INSURANCE: _____ POLICY NUMBER: _____

DISABILITY: _____ SPECIAL NEEDS: _____

MEDICAL CONDITIONS THE NURSE SHOULD BE AWARE OF:

ADHD / ADD / Depression / Anxiety (circle) Name of medication: _____

*Asthma: YES__ NO__ Requires asthma medication? YES__ NO__ Inhaler: _____

*Severe Bee/Insect Sting Reaction: YES__ NO__ Requires an Epi-Pen? YES__ NO__

*Peanut Allergy: YES__ NO__ Requires an Epi-Pen? YES__ NO__

Medication Allergies: _____ Other Allergies: _____

*Bleeding Disorders: _____

Celiac Disease / IBS (circle) Stomach Issues: _____

*Convulsions / Epilepsy / Seizures: (circle) Emergency medications: _____

*Diabetes: YES__ NO__ Insulin dependent: YES__ NO__ Medications: Oral__ Injection__ Pump__

Head Injury / Concussion: YES__ NO__ DATE: _____

Hearing Impairment: YES__ NO__ Right/Left/Both (circle) Wears Hearing Aids: YES__ NO__

Heart Condition: YES__ NO__ List: _____ Surgery Date: _____

Migraines: YES__ NO__ Medication required: _____

Other Medical Conditions: _____

TREATMENT FOR HEALTH CONDITIONS: _____

INJURIES: _____ BODY PART: _____

YEAR: _____ TREATMENT: _____

INJURIES: _____ BODY PART: _____

YEAR: _____ TREATMENT: _____

CURRENT MEDICATIONS: _____ ROUTE: _____

START DATE: _____ END DATE: _____

CURRENT MEDICATIONS: _____ ROUTE: _____

START DATE: _____ END DATE: _____

CURRENT MEDICATIONS: _____ ROUTE: _____

START DATE: _____ END DATE: _____

DATE OF LAST TETANUS VACCINATION: _____

*****If your child has a condition or health issue that is not mentioned on this form, please write concerns on page 3 of this form explaining details.*****

Signature of Parent/Guardian

Date

****MEDICATION CANNOT BE GIVEN AT SCHOOL WITHOUT A PHYSICIAN’S ORDER AND THE COMPLETION OF APPROPRATE FORMS (AVAILABLE ONLINE OR IN THE NURSE’S OFFICE).**

This includes the use of Epi-Pens, Asthma Inhalers & Insulin.

ALL medications MUST be delivered to the nurse by an adult.

ALL medication must be given to the nurse in the original container and be properly labeled.

***Upon review of this form, the BCAVTS School Nurse may send home additional detailed medical forms to be completed by parent or guardian.**

Parent/Guardian and Student: Please complete this form as soon as possible.

Also, please contact BCAVTS Nurse at (724) 282-0735 Ext. 238 or FrederickJ@butlertec.us with any questions or concerns.

Medical Information will be released to instructors, as needed for student safety.

For more information or for a new student medical form, please go to:

www.butlertec.us

Family Hub » School Nurse



