E.D. Feehan Catholic High School- **GENERAL MEDICAL INFORMATION FORM**

Student Name: _____ Date of birth: _____

Address: _____

Grade: _____

Siblings at E.D. Feehan: _____

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Parent/Guardian Name: _____

Phone: (home) _____ (work) _____ (cell) _____

Emergency Contact: _____

(home phone) _____ ( cell ) _____

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1. Does your child require assistance taking prescribed medication at school?

   Yes_____Name of medication: _____

   No._____

2. Does your child have a medical condition which can cause a situation requiring emergency medical assistance from staff? (ex. epilepsy, asthma, severe food allergy, etc.)

   Yes_____Name of condition: _____

   No_____

3. Does your child require staff to provide medical services daily? (ex. catheterization, tube feeding, monitoring of glucose, ostomy care, etc.)

   Yes_____Medical Service required: _____

   No_____

4. Does your child require staff to provide personal care? (ex. lifting, positioning, toileting, feeding, assistance with mobility, etc.)

   Yes_____Personal Care Needed: _____

   No_____

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Parent/Guardian Signature: _____ Date:_____