ISBVI Medical Information Form and Physical Exam Form
Academic Year 2024-2025

Name: ____________________________________ DOB:___________________________________ Gender: ☐Female ☐Male

Please check all that apply to your child. Please list on the back of the form if more room is needed.

Medical Conditions/Illness:

1. ☐Eye Condition/Vision Problems
   a. Diagnosis: ____
   b. Does your child use: ☐ Glasses ☐Contacts ☐No corrective eyewear
2. ☐Asthma
   a. If YES, does your child have a rescue inhaler? ____ YES ____ NO
   b. If applicable, please provide an Asthma Action Plan from your provider
3. ☐ Seizures. Date of last seizure: ______________________
   a. If your child requires emergency medication for seizures as part of treatment, please provide a supply and provide order (this can be the prescription instructions)
   b. Please provide a Seizure Action Plan from your provider
4. ☐Allergies
   a. If YES, does your child experience Anaphylaxis or a severe life-threatening reaction? ____YES ____NO
   b. Allergen: _________________________________
   c. If an Epi-Pen is required, please provided a personal supply and provider order (this can be the prescription instructions)
   d. If applicable, please provide an Anaphylaxis Action Plan from your provider
5. ☐Cerebral Shunt
   a. If YES, which side? ☐RIGHT ☐LEFT
6. ☐Digestive disorders. Explain: ____
   a. If your child requires enteral/ G-tube feedings, please have your provider fill out a G-tube Feeding Action Plan
7. ☐Diabetes. Does your child require insulin? ____ YES ____NO
   a. If YES, please provide the name of medications: ____
8. ☐Hearing Problems
   a. If YES, does your child use hearing aids ____ YES ____ NO☐
9. ☐Other medical conditions that the health center should be aware of? Explain: _________________________
10. ☐Orthotics, Braces, Prosthetics? List: ____
11. Current medications: ____
12. Allergies (ones not listed as severe above)? ____

Past Medical History:

☐Hospitalizations. If YES, please include reason and dates: ____

☐Surgery. If YES, please include type and dates: ____

Restrictions:

☐Activity Restrictions. If YES, please explain: ____

☐Dietary Restrictions. If YES, please explain: ____

<u>APPLIES TO ALL STUDENTS***</u>**

PLEASE PROVIDE A CURRENT IMMUNIZATION RECORD FROM YOUR CHILD'S PROVIDER. If your child is exempt due to religious or medical reasons. Please provide the appropriate documentation.

Parent/Guardian Signature: ____ Date: _______________