



# Family Vitals™

## School Medical Information & Authorization Form

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### Student Information

- **Student Full Name:** \_\_\_\_\_
  - **Date of Birth (MM/DD/YYYY):** \_\_\_\_\_
  - **Grade / Classroom / Homeroom:** \_\_\_\_\_
  - **School Name & District:** \_\_\_\_\_
  - **Student ID (if applicable):** \_\_\_\_\_
  - **Primary Language Spoken at Home:** \_\_\_\_\_
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### Parent / Legal Guardian Information

**Primary Guardian - Name:** \_\_\_\_\_

**Relationship to Student:** \_\_\_\_\_

**Phone (Mobile):** \_\_\_\_\_

**Phone (Work):** \_\_\_\_\_

**Email:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Secondary/Emergency Guardian - Name:**

\_\_\_\_\_

**Relationship:** \_\_\_\_\_

**Phone:** \_\_\_\_\_

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### Emergency Contacts (Other Than Parent/Guardian)

1. **Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

2. **Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

This medical view is intended to display certain health information entered by Primary Guardian or made available to a school and may not accurately reflect the full medical history. This summary is not intended to replace official health records or professional medical judgment. Please consult with your healthcare provider prior to making any health decisions related to your health.

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## Primary Care & Insurance Information

- **Primary Care Provider (PCP):** \_\_\_\_\_
- **Clinic / Practice Name:** \_\_\_\_\_
- **Phone:** \_\_\_\_\_
- **Preferred Hospital / ER:** \_\_\_\_\_

**Health Insurance - Provider:** \_\_\_\_\_ -  
**Policy / Member ID:** \_\_\_\_\_

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## Medical History (Check all that apply)

- Asthma / Reactive Airway Disease
- Severe Allergies (food, insect, medication)
- Diabetes (Type  1  2)
- Seizure Disorder / Epilepsy
- Heart Condition
- Sickle Cell Disease or Trait
- Bleeding Disorder
- ADHD
- Autism Spectrum Disorder
- Anxiety / Depression
- Other (specify): \_\_\_\_\_

### Brief Explanation / Notes:

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## Allergies & Intolerances

### Food Allergies:

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### Medication Allergies:

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## Environmental Allergies:

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- **Does the student require an emergency medication (e.g., EpiPen)?**  Yes  No
  - **If yes, medication is provided to school:**  Yes  No
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## Current Medications (School-Time or As-Needed)

Include prescription and over-the-counter medications.

Medication Name	Dose	Time/ Frequency	Reason	Self-Carry Allowed?
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No

*Separate medication authorization forms may be required by the school.*

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## Chronic Conditions & Care Plans

- **Condition:** \_\_\_\_\_
  - **Action Plan on File?**  Yes  No (Asthma, Allergy, Diabetes, Seizure, etc.)
  - **Triggers / Warning Signs:** \_\_\_\_\_
  - **School Accommodations Needed:** \_\_\_\_\_
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## Immunization Record

Attach official immunization documentation as required by state law.

- Immunizations are **up to date** per state requirements
- Medical Exemption (documentation attached)
- Religious/Personal Belief Exemption (where permitted)

**Date of Last Physical Exam:** \_\_\_\_\_

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## Physical Activity & Sports Participation

- **May participate in regular physical education:**  Yes  No
  - **Activity restrictions (if any):** \_\_\_\_\_
  - **Requires medication before/during activity:**  Yes  No
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## Vision, Hearing, and Special Needs

- **Vision concerns or corrective lenses:**  Yes  No
- **Hearing concerns or devices:**  Yes  No
- **Individualized Education Plan (IEP) or 504 Plan:**  Yes  No

**Details:**

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## Consent & Authorization

I authorize the school and its designated personnel to: - Access and use this medical information for student care and safety - Provide basic first aid and emergency treatment as needed - Share relevant health information with school nurses, staff, and emergency responders

I understand that in a medical emergency, reasonable efforts will be made to contact me, but emergency services may be contacted if necessary.

- **Parent/Guardian Name (Print):** \_\_\_\_\_
  - **Signature:** \_\_\_\_\_
  - **Date:** \_\_\_\_\_
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## Healthcare Provider Section (If Required by School)

- **Provider Name & Title:** \_\_\_\_\_
  - **Practice Stamp:** \_\_\_\_\_
  - **Signature:** \_\_\_\_\_
  - **Date:** \_\_\_\_\_
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