ANNUAL MEDICAL ALERT

John Rex Charter Elementary School

STUDENT NAME: ____ DATE OF BIRTH: __________

PARENT/LEGAL GUARDIAN: __________________________SCHOOL YEAR: ________GRADE: ___

A signed copy of this form must be turned in to the office as part of the annual enrollment.

If prescription medication is to be administered at school, it **must** be in the *original* prescription container **and** the form *Authorization for the Administration of Medication* must be signed by the prescribing physician and parent/legal guardian.

_____ My child does **not** have any medical conditions.

_____ My child does have medical condition(s).
Please check and explain any medical conditions your child has that you would like the school faculty and staff to be informed of.

Conditions	Treatment
Allergies: ❏ Hay Fever ❏ Reactions to Insect Bites/Stings ❏ Medications ❏ Foods ❏ Other ___________________	
Asthma	
Diabetes	Action Plan required. See office.
Seizure Disorder	Action Plan required. See office.
Hearing Problems	
Visual Problems: ❏ Glasses ❏ Contact Lenses	

PHYSICAL EDUCATION CLASS:

____ My child can participate in P.E. with **NO** restrictions.

____ My child can participate in P.E. **with certain** restrictions. EXPLAIN: ________________________
____

____ My child CANNOT participate in P.E. because of medical restrictions. *(Physician's note required)*

Parent/Legal Guardian Signature: ____ Date: ________