PHOENIX SCHOOL

Medical Information & Dietary Preference

Child's Name _____ _____ _____
Last *First* *Middle*

Date of Birth (MM/DD/YY): _____ Age: _____ Gender: Male ☐ Female ☐

Does the child have any current or past medical problems that we should be aware of (asthma, sun sensitivity, etc.)? _____

_____

_____

Does the child have any known allergies? No ☐ Yes ☐

Allergy (Substance): _____
Reaction (Symptom): _____
Treatment: _____

Allergy (Substance): _____
Reaction (Symptom): _____
Treatment: _____

Allergy (Substance): _____
Reaction (Symptom): _____
Treatment: _____

Does the child have any specific dietary needs or preferences? No ☐ Yes ☐, please describe _____

_____

_____

Does the child take any medications regularly or frequently? No ☐ Yes ☐, please describe*: _____

_____

_____

Can this child participate fully in all school activities without restriction? Yes ☐ No ☐, please provide details: _____

_____

_____

Parent/Guardian (Signature): _____

Parent/Guardian (Printed Name): _____ Date: _____

* You will need to fill out a Medication Authorization Form for each medication.