MEDICAL DATA FORM

_____ (DATE OF BIRTH)

_____ (STUDENT'S NAME)

VOCATIONAL PROGRAM Circle One 9 10 11 12

_____ SOCIAL SECURITY NUMBER

FATHER'S PLACE OF EMPLOYMENT: _____Phone #_____

MOTHER'S PLACE OF EMPLOYMENT: _____Phone # _____

OTHER EMERGENCY CONTACT: NAME: _____Phone # _____

RELATIONSHIP: _____

DOES THIS STUDENT HAVE ANY OF THE FOLLOWING CONDITIONS? CIRCLE YES OR NO

NO	YES	ASTHMA	NO	YES	HEART TROUBLE
NO	YES	DIABETES	NO	YES	HEMOPHILIA (BLEEDER)
NO	YES	EPILEPSY	NO	YES	OTHER MAJOR HEALTH CONCERNS
NO	YES	FAINTING SPELLS			

HAS THIS STUDENT HAD SURGERY? _____(SPECIFY)

_____

_____

_____

DOES THIS STUDENT WEAR CONTACT LENSES? _____

DOES THIS STUDENT HAVE ANY KNOWN ALLERGIES TO FOODS, DRUGS, OR INSECT STINGS? _____

IS THIS STUDENT TAKING ANY MEDICATION ON A REGULAR BASIS? _____

_____(SPECIFY)

DATE OF MOST RECENT TETANUS (LOCKJAW) SHOT: _____

_____
(SIGNATURE OF PARENT OR GUARDIAN)