



Region 7 Education Service Center, Kilgore, Texas 75662

MEDICAL CONDITIONS FORM

Early/Head Start Child EHS Pregnant Mom (check one)

Name: _____ Birthdate: _____

School/Site: _____

Parent/Guardian Name: _____ Phone: _____

Emergency Contact Name: _____ Phone: _____

Doctor's Name: _____ Phone: _____

Dentist's Name: _____ Phone: _____

CONDITION:

ASTHMA Yes No

*If **YES**, please list all medications prescribed.*

SEASONAL ALLERGIES Yes No

FOOD ALLERGIES Yes No

OTHER ALLERGIES Yes No

Circle all that apply: Insects (type) Medicine (name) Other(describe)

EPI PEN Yes No

*If **YES**, must have EPI Pen on campus before child can attend school.*

DIABETES Yes No

SEIZURES Yes No

HEART/BLOOD Yes No

MUSCLES/BONES/JOINTS Yes No

BLADDER/KIDNEY Yes No

STOMACH/INTESTINES Yes No

GROWTH/NUTRITIONAL/EATING CONCERNS Yes No

EMOTIONAL/BEHAVIORAL Yes No

OTHER HEALTH CONCERNS Yes No

If yes, please explain:

***PROVIDE DETAILS HERE: List specific allergies; list all medication(s) taken at school and/or home.**

Has medical condition been diagnosed by a Doctor? Yes No Emergency Action Plan from Doctor? Yes No

Parent/Guardian Signature: _____ Date: _____

FSW/FSA Signature: _____ HS Nurse Signature: _____

