



Student Change of Medical Information

Student name: _____ Date of change: _____

Student DOB: _____

Please list current medications:

Medication	Reason	Dosage	Administration During School?	Date Started

Please list any allergies or allergic reactions (if has experienced, reacted to what and at what age?)

Comments: _____

Medical Insurance: _____

Policy #: _____ Policy Holder (whose name is it in): _____

Parent/Guardian name _____

Parent/Guardian signature _____