

2009 - 2010 Questionnaire

Medical

Student Name _____

Date of Birth _____ Grade _____

Has or Does your child suffer from any of the following:

	Yes	No
Asthma	_____	_____
Diabetes	_____	_____
Seizures	_____	_____
Deafness	_____	_____
Bladder/Kidney Problems	_____	_____
Hemophilia	_____	_____
Sickle cell Anemia	_____	_____
Sight Impairment/Blindness	_____	_____
ADD/ADHD	_____	_____
Other not listed (Please specify) _____	_____	_____

Known Allergies: _____

Medications: _____

I, _____, am the parent or legal guardian of, _____, a student at St. Augustine's Mission School. By my signature below I am authorizing the staff of the school to administer Tylenol as needed to my child in accordance with the distributor's package directions.

Parent/Guardian Signature

Date