STUDENT MEDICAL HISTORY

Immanuel Lutheran High School and College
Eau Claire, WI

Student Name:_____ Date o f Birth:_____

Form Completed by:_____Date Completed:_____

Allergies (Medication, Food, Bee Sting, Latex, etc)

Allergen	Reaction	Does Student Have a Reaction Kit?

Current Medications

Mediation Name	Prescribed or OTC	Purpose	Dosage	To Be Administered By

Medical Conditions or Concerns

Please describe any physical or mental health conditions of which the school should be aware.

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Does the student have any limitations or restrictions for participation in Physical Education class? ☐YES ☐NO (If yes, explain below)

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