ALL SAINTS' PRESCHOOL
PARENT/GUARDIAN MEDICAL DISCLOSURE

PO Box 248 | 4-1065 Kuhio Highway | Kapaa, HI 96746-0248 | (808) 822-0122 | www.allsaintskauaipreschool.org

Form to be completed by a parent or legal guardian.

_____ _____ DOB:____/____/_____

Student's **LAST** Name **FIRST** Name

Please list all routine medications and doses being taken by this student:_____

_____

_____

Does this student require any emergency medication to be stored on campus? (e.g. epi-pen, inhaler)_____

_____

_____

Please document any other physical or emotional issues with this student:_____

_____

_____

_____ _____

Name of Student's Pediatrician or Physician *Telephone of Student's Pediatrician or Physician*

_____ _____

Name of Additional Physician Overseeing Student's Care *Telephone of Other Physician*

Please respond to each question. For any conditions answered "yes" please explain below.

Asthma:	Yes	No	Concussion/Head Injury:	Yes	No
Diabetes:	Yes	No	Migraines/Headaches:	Yes	No
Glasses:	Yes	No	Thyroid problems:	Yes	No
Contacts:	Yes	No	Frequent Bronchitis:	Yes	No
Hearing Impairment:	Yes	No	Frequent Nosebleeds:	Yes	No
Frequent Ear Infections:	Yes	No	Scoliosis:	Yes	No
Seizures:	Yes	No	Mental Health Problems:	Yes	No
Hepatitis:	Yes	No	Anxiety:	Yes	No
Heart Condition:	Yes	No	Depression:	Yes	No
History of Fainting:	Yes	No	Eating Disorder:	Yes	No
Kidney/Urinary problems:	Yes	No			

Explanation: _____

_____

_____

_____