

**OXFORD CENTRAL SCHOOL
ANNUAL STUDENT MEDICAL UPDATE
2023/2024**

STUDENT

NAME: _____ **GRADE/TEACHER:** _____

Does your child have **asthma** diagnosed by a physician? Yes _____ No _____
Has your child had any **reactions to medications, foods or insects?** Yes _____ No _____
If yes, please list type of reaction and care required. _____

Does your child take any **medications on a daily basis?** Yes _____ No _____
If yes, please indicate name of medication, amount, reason for medication and time of administration. _____

Please list any **illnesses** your child has had in the past year (include dates).

Please list any **injuries** your child has had in the past year (include dates).

Has your child had any **surgical procedure or medical test** in the last year? If yes, provide details. _____

Does your child wear **glasses?** Yes _____ No _____ **Contacts?** Yes _____ No _____ If so, is the correction for near vision _____ or distance vision _____.

Please list any other health concerns you have for your child: _____

PLEASE CONTACT THE SCHOOL NURSE WITH ANY SPECIAL ISSUES OR CONCERNS—908-453-4101 Ext: 2106

Medical Information

Physician Name: _____ Phone #: _____

**I give permission for the School Nurse to inform the appropriate staff members of my child's medical condition(s) and/or special need(s).

Parent/Guardian _____ **Date:** _____
Signature: _____