

ALLERGIES _____ MEDICATIONS PRESCRIBED _____

MEDICAL CONDITIONS OR OTHER PROBLEMS _____ INSTRUCTIONS OR DOSAGE _____

Please indicate the following PROCEDURES CARED FOR DURING THE SUMMER.

Eyes examined _____ Date _____ Glasses prescribed YES () NO ()

Immunization received _____ Dates _____

Date of last complete physical examination _____ Dental Examination _____

Doctor or Examiner _____ Doctor's Office Number _____

Dentist _____ Dentist's Office Number _____

Serious injury or illness or other pertinent Information _____

Does this child have legal court papers? _____ (If yes, please provide a copy with this form.)

Bus Stop (Corner) _____ Color Code of Bus _____ Check here if student walks _____

Brother/Sister	Date of Birth	School Attending	Pre-School/Grade/Teacher

Do you give permission to share this information with the staff? ___ Yes ___ No

In an emergency, I give permission to the staff of Sayre Area School District to transport or to make arrangements for the transportation of my child to the nearest medical facility for medical care.

Signature of Father/Guardian _____ Date Signed _____

Signature of Mother/Guardian _____ Date Signed _____

Signature of Student _____ Date Signed _____

Race (Optional) – White (), Hispanic (), Black/Non-Hispanic (), Asian (), American Indian ()

MUST BE RETURNED TO THE MAIN OFFICE WITHIN 5 SCHOOL DAYS