MEDICAL INFORMATION CARD FOR TRANSPORTATION

Student ______________________________ District ______________________

Birth Date ______/______/______ Receiving School ______________________

Parent/Guardian Name ______________________________ Phone (home) ____________

Home Address ______________________________ Phone (work) ____________

SEIZURE PROTOCOL: ______________________ MINUTES (911 NEEDS TO BE CALLED IMMEDIATELY AFTER THE SPECIFIED NUMBER OF MINUTES.)

Description of the Seizures

____

____

Primary Physician ______________________________ Phone (   ) ____________

Other Physician ______________________________ Phone (   ) ____________

Allergies/Sensitivities

____

Other Medical Conditions

____

Current Medications ______________________ Dose ______________________

______________________ Dose ______________________

______________________ Dose ______________________

Attach student photo here:

Nurse Signature ______________________________ Date ____________

Parent Signature ______________________________ Date ____________

If there is a change in any of this information, please fill out a new card and return it to the schooll nurse with your signature and date as soon as possible.