THE ROBERTS ACADEMY
AT FLORIDA SOUTHERN COLLEGE

2025-2026
Medical Information Form

Student_____
Last First Middle

Student ID# _____ Grade:_____ Birth Date____/____/_____ Gender: M / F
MM/DD/YYYY

Primary Parent/Guardian Name: _____

Primary Parent/Guardian Cell Phone Number: (____) (_____-_____)

Primary Parent/Guardian Email Address:_____

Address: _____
Street City Zip

Please circle any conditions that apply to your child.

1. Asthma/breathing problems
2. ADD/ADHD
3. Bladder problems
4. Bleeding problems
5. Bone/joint problems
6. Bowel problems
7. Cancer
8. Cystic fibrosis
9. Dental (tooth) problems/braces
10. Diabetes
11. Epilepsy/seizures
12. Headaches (severe)
13. Heart problems
14. Kidney problems
15. Mental health problems
16. Nosebleeds (frequent)
17. Sickle cell disease

Please explain any circled items or other serious surgeries, illnesses, or injuries:_____

_____

_____

In your opinion, might any of the problems circled above, or any other medical condition your child has, affect his/her school performance, program, or ability to participate in a regular physical education program? Yes_____ No_____

If yes, please explain: _____

_____

Please list allergies/reactions and check the appropriate column stating the severity of each:

		Severity of Reaction				
	My child is allergic to:	None	Mild	Moderate	Severe (needs meds)	Life-Threatening (Call 911)
Insect stings/bites						
Food/Plants/Other						
Medicines						

Has your child been diagnosed with asthma by a doctor? Yes_____ No_____

If yes, what treatment has been prescribed? _____Inhaler _____Nebulizer _____Other, please list:_____

Does your child need to take any medications (prescription or over-the-counter) or require any medical treatment at school?
Yes_____ No_____

If yes, please list: _____

If yes, parent must provide a new Authorization for Medication form each school year. All medications must be brought to school by an adult.

I understand and agree that certain educational records of my child may be shared with Florida Southern College's health care partners as needed to provide and evaluate health services to students. I also understand and agree that my child's medical treatment records created by healthcare personnel at school may be shared with school officials who have a legitimate educational purpose for accessing such records. I understand that it is my responsibility to notify the school of any changes in the information recorded on this form.

_____ _____ _____
Primary Parent/Guardian Signature Primary Parent/Guardian Name Printed Date