Indian Valley Local Schools
Kindergarten Medical Information

Midvale____Port Washington____Date_____

Student's Name_____

Allergies_____

(If YES, what reaction and treatment?)

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Any Food Allergies?_____

(If YES, what reaction and treatment?)

_____

Asthma_____

(If YES, what Action plan and medication?)

Inhaler_____

Bee Sting Allergy_____

(If YES, what reaction and treatment?)

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Epi-Pen?_____

Seizures_____

(If YES, what seizure plan and medications?)

Diabetes_____

(If Diabetic, list treatments, medications?)

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Chronic Illness/Surgery_____

_____

Medications_____

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