THE EPIPHANY SCHOOL OF CHARLOTTE

1000 E. Morehead Street. Charlotte, NC 28204
704-496-9942
www.epiphanyschoolcharlotte.com

Student Medical History
2024-2025

This report should be completed by the applicant's primary care physician. The physician needs to return this form along with the patient's vaccine/immunization shot record. These can be mailed directly to the address above % Epiphany School or returned to the school by the parents/guardians.

To be completed by Parent:

Child's Full Name:_____

Primary Care Pediatrician/Group with Phone Number: _____

_____

Hospital Preference:_____

Emergency Contact Name and Phone Number:_____

_____

Medication(s)/Supplements

Please list all of the Student's current medications/supplements THAT ARE GIVEN AT SCHOOL (Include any 'as needed medications such as Tylenol)

Medication	Prescribing Physician	Dosage / Time Taken	Reason

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In signing below, I (parent/guardian) give the Epiphany School of Charlotte permission to administer the aforementioned medications to my child:

Parent's Signature/Date:_____

To be completed by Physician:

Does this child have a medical condition that permits him/her from participating in P.E. or other physical activities? If yes, please explain.

_____
_____
_____

Does this child have any chronic or significant conditions such as asthma, allergies, or epilepsy?If yes, please name and describe below.

_____
_____
_____
_____
_____
_____

Is the Student currently diagnosed with ADHD? Yes___ No___
If yes, date of diagnosis: _____
If yes, does the student take medication for ADHD? Yes___ No____
**Please list in chart above if this medication is administered during school hours by school staff

Physician's Name: (please print)_____

Physician's Signature: _____ Date:_____

Phone:_____

Please feel free to contact Cassie Jones, Head of School with any questions:
cassie.jones@epiphanyschoolofcharlotte.com