MODEL SECONDARY SCHOOL FOR THE DEAF

______________________________ ______________________
Child's Printed Name Date of Birth

If your child is **NOT** taking any prescribed or over the counter medication, please check (✓) here ☐ and sign your name and date here.

____.

Return this form with MSSD Student's Medical History From.

MSSD PARENTS/GUARDIANS: If your child is taking any prescribed medication, take this form to your physician to complete the form. Return this form with MSSD Student's Medical History Form.

Diagnosis: ____

____

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NAME OF MEDICINE	DOSAGE/FREQUENCY	SIDE EFFECTS

Is patient authorized to take medicine himself/herself? ❑ Yes ❑ No

Dates medicine should be administered are from: ______________ to ______________

Comments: ____

____

______________________________ (______)______________
Physician's Name Phone Number

______________________________ (______)______________
Street Fax Number

____
City/State/Zip

______________________________ ______________________
Physician's Signature Date