



Medical Information Form
The Literacy Corner 2009
Furman University

Child's Name: _____ Age: _____

Parent/Guardian Name(s): _____

Phone: _____

List any specific allergies: _____

Is medication for allergy being given? Yes No

If yes, indicate name of medication: _____

If yes, are there any side effects? (Please describe) _____

Is your child on any medication for behavior control? Yes No

(Hyperactivity, attention deficit, depression, etc.)

If yes, please indicate name of medication: _____

If yes, are there any side effects? (Please describe) _____

Is your child on any medication for epilepsy or other convulsive disorder? Yes No

If yes, please indicate name of medication: _____

If yes, are there any side effects? Please describe: _____

Please explain any other medical difficulties of which we should be aware: _____

Please return this form by May 20 to: Dr. Renita Schmidt, Director
The Literacy Corner
Education Department
3300 Poinsett Highway
Greenville, SC 29613-1134