STUDENT HEALTH RECORD

Student name: ____ DOB: ________________

Parent/Guardian name: _______________________________________ Grade: _______________

Address: ____

Phone: __________________________________ Email: _______________________________

Name of child's current *physician*: ____

Phone: __________________________________ Date of last examination: _______________________

Name of child's current *dentist*: ____

Phone: __________________________________ Date of last examination: _______________________

Childhood Illnesses

☐Chicken Pox ☐Pertussis ☐Scarlet Fever ☐Rheumatic Fever
☐German Measles ☐Measles ☐Pneumonia ☐Mumps
☐Other: ____

Does your child have any known allergies: ☐No ☐Yes ____

Has your child had any operations: ☐No ☐Yes ____

Is your child presently under medical treatment: ☐No ☐Yes ____________________________________

Does your child have any problems with vision, hearing, speech or communication: ☐No ☐Yes

May your child have Tylenol: ☐No ☐Yes My child has a history of ear infections: ☐No ☐Yes

Any known illnesses or chronic conditions which you or your family physician feel should be made known to school authorities:
☐No ☐Yes ____

I hereby give my permission for my child's medical information to be shared with the faculty and/or staff members who need to know in order to provide for my child's health and safety: ☐No ☐Yes

I hereby swear or affirm that the facts contained herein are true and correct to the best of my knowledge, information and belief.

______________________________________ ________________________
Signature of parent/guardian *Date*