

**ALBERT BRIDGE SCHOOL
STUDENT HEALTH FORM
2015-2016**

Name of child _____ Sex M ___ F ___ Date of Birth _____

Physical Address _____

Parent/Guardian _____ Parent/Guardian _____

Student lives with: _____

Guardian _____ Legal Concerns _____

Child's Physician _____ Date of last exam _____

Physician's address _____ Phone _____

Health Care Facility _____

Dentist _____ Date of last exam _____

Dentist address _____ Phone _____

ALLERGIES: Please list your child's allergies (food, insect bites, medication etc.), reaction symptoms and treatment.

Allergy _____ Symptom _____

Treatment _____

Allergy _____ Symptom _____

Treatment _____

MEDICAL NEEDS: Does this child have any behavioral or psycho/social challenges?
If yes, please explain _____

Does this child have any disabilities or activity limitations? If yes please explain

SIGNIFICANT MEDICAL HISTORY

- | | |
|-----------------------------|------------------------------------|
| ___ Asthma | ___ Bronchial/Respiratory Problems |
| ___ Stomach Aches | ___ Bowel Problems |
| ___ Vision Problems | ___ Ear Infections |
| ___ Diabetes | ___ Bleeding Problems |
| ___ Seizures | ___ Cavities/dental Problems |
| ___ Bladder/Kidney Problems | ___ Skin Problems |
| ___ Fainting | ___ Heart Condition |
| ___ Headaches | ___ Sinus Infections |
| ___ Hearing Problems | ___ Speech Problems |

Other _____

Operations _____

MEDICATIONS: Please list all medications and reason for taking. _____

IMMUNIZATIONS RECEIVED IN PAST YEAR: _____

HEALTH INSURANCE: Do you have health insurance? _____

NAME OF INSURANCE COMPANY: _____

In case of an accident, the school will make every effort to contact me. If unable to reach me, I hereby authorize the school personnel to seek emergency medical care, including transportation to an emergency room. I hereby authorize the physician in charge to administer whatever emergency treatment is necessary.

SIGNATURE: _____ **DATE:** _____