

**ALBERT BRIDGE SCHOOL
STUDENT HEALTH FORM
2019-2020**

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