STUDENT HEALTH INFORMATION

THIS FORM MUST BE COMPLETED EACH SCHOOL YEAR.
THIS INFORMATION MAY BE SHARED WITH OTHER SCHOOL STAFF AS NEEDED.

Student's Name _____ Gender M F Grade _____
Home Address _____ Date of Birth _____
Father's Name _____ Phone Number _____
Mother's Name _____ Phone Number _____
Student Lives With _____ Both Parents _____ Mother _____ Father _____ Guardian (Name _____)

EMERGENCY CONTACTS (IN CASE PARENT/GUARDIAN CANNOT BE REACHED)

Name _____ Relationship _____ Phone Number _____
Doctor _____ Phone Number _____
Dentist _____ Phone Number _____
Hospital Preference (in case of emergency) _____

DOES YOUR CHILD HAVE:			PLEASE EXPLAIN IF ANSWER IS YES
Allergies? (Food/Insects/Medication)	___ Yes	___ No	List of allergies/reactions: _____ _____ _____ _____ If exposed, does your child need? *(circle one)* Benadryl Epi-pen Both Food allergy form on file with Child Nutrition? *(circle one)* Yes No
Asthma/Reactive Airway Disease?	___ Yes	___ No	Inhaler required at school? *(circle one)* Yes No
Bladder/Bowel Problems?	___ Yes	___ No	_____ *(Parents will be called to change child if necessary.)*
Blood or Clotting Disorder/Cancer?	___ Yes	___ No	_____
Bone or Joint Problems?	___ Yes	___ No	_____
Congenital (Birth) Defect(s)?	___ Yes	___ No	_____
Diabetes/Blood Sugar Issues?	___ Yes	___ No	Type: *(circle one)* 1 2 Insulin dependent? *(circle one)* Yes No
Recent Surgery?	___ Yes	___ No	_____
Hearing Difficulty/Hearing Aid(s)?	___ Yes	___ No	_____
Heart Disease or Defect?	___ Yes	___ No	_____
Migraines/Headaches?	___ Yes	___ No	Medication: _____
Seizures?	___ Yes	___ No	Type: _____ Medication: _____ Date of last seizure: _____ Precautions/Restrictions? _____
Skin Problems/Rashes?	___ Yes	___ No	_____
Stomachaches?	___ Yes	___ No	Medication: _____
Vision Difficulties?	___ Yes	___ No	Glasses or Contacts? _____
Does your child have health insurance?	___ Yes	___ No	Name of Insurance Provider _____

OTHER HEALTH CONCERNS (INCLUDING HOSPITALIZATION OR SURGERIES NOT MENTIONED)

_____
_____
_____

IS THE STUDENT TAKING ANY MEDICATIONS AT HOME OR SCHOOL? PLEASE LIST AND EXPLAIN.

_____
_____

Notice: In the event of illness or accident to our student, requiring immediate medical or dental attention, and if school authorities are unable to contact us, we hereby authorize and empower the principal, teacher or school nurse, acting as our agent and attorney-in-fact to secure immediate medical or dental attention from our family doctor/dentist acting in his absence, or the hospital or dental clinic we have listed. I know of no health reason(s), other than the information indicated on this form, why my child should not participate in any school activity.

Parent/Legal Guardian Signature: _____ **Date:** _____