

Homeroom Teacher: \_\_\_\_\_



2025-2026  
EMERGENCY CARD/STUDENT HEALTH INFORMATION

Student Full Name: \_\_\_\_\_ Grade Level: \_\_\_\_\_

**EMERGENCY CONTACT INFORMATION (Other than Custodial Guardian/Parent):**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Primary Phone: \_\_\_\_\_ Can pickup?  Yes  No

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Primary Phone: \_\_\_\_\_ Can pickup?  Yes  No

Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

**Please complete the following information about your child's health history. The information given below is confidential and remains in the health office. It is needed for accurate evaluation and emergency situations.**

**Allergies: Does your child have any allergies to the following?**

Plants	Yes ___ No ___	Type _____	Reaction _____
Food	Yes ___ No ___	Type _____	Reaction _____
Bees/Insects	Yes ___ No ___	Type _____	Reaction _____
Drugs	Yes ___ No ___	Type _____	Reaction _____
Animals	Yes ___ No ___	Type _____	Reaction _____

Others not listed: \_\_\_\_\_

List **All Prescription Medications** your child is taking at home \_\_\_\_\_

Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bladder Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vision Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bowel Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bleeding Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chronic Ear Infections	<input type="checkbox"/> Yes <input type="checkbox"/> No
Nose Bleeds	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seizure Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Is there anything else we should know about your child? \_\_\_\_\_

Does your child wear glasses?  Yes  No If yes, date of last exam \_\_\_\_\_

**If emergency treatment is necessary, I hereby give permission for my child to be taken to the nearest doctor or hospital and agree to pay all fees in connection with such treatment or service not covered by insurance.**

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Date