

STUDENT HEALTH FORM 2026-2027

Student's Legal Name (as appears on birth certificate): _____
 (First) (Middle) (Last) (Jr., III, etc)

Date of Birth: _____ Gender: M F Grade Level _____ State ID or Social Security Number: _____

Student's Address _____ City _____ Zip _____

Mailing Address (If PO Box is used) _____ City _____ Zip _____

Primary Parent/Guardian Information (with whom the student lives) ___ Both Parents or ___ Father ___ Step Father or ___ Mother ___ Step Mother or ___ Other Guardian

Parent/Guardian's Name #1: _____ Relationship to Student: _____

Home Phone: (____) _____ - _____ Work Phone: (____) _____ - _____ Cell Phone: (____) _____ - _____

Email Address: _____

Parent/Guardian's Name #2: _____ Relationship to Student: _____

Address of P/G #2 (if different) _____ City _____ Zip _____

Home Phone: (____) _____ - _____ Work Phone: (____) _____ - _____ Cell Phone: (____) _____ - _____

Email Address: _____

Emergency Contacts (To be used only if the Parent/Guardian cannot be reached; they may also pick up/check out my child from school)

Contact's Name #1: _____ Relationship to Student: _____

Home Phone: (____) _____ - _____ Work Phone: (____) _____ - _____ Cell Phone: (____) _____ - _____

Contact's Name #2: _____ Relationship to Student: _____

Home Phone: (____) _____ - _____ Work Phone: (____) _____ - _____ Cell Phone: (____) _____ - _____

Doctor Name: _____ Business Phone Number: _____

Permission to Receive Healthcare Services in Accordance with Senate Bill 12:

☐ I give permission for my child to receive legally permitted routine health-related services/first aid at school during the current school year.

☐ I DO NOT give permission for my child to receive legally permitted routine health-related services/first aid at school during the current school year.
 In the event of a medical emergency, WISD staff will provide life-saving care and/or contact emergency services.

Medication My student may have	Acetaminophen		Ibuprofen		Cough Drops	
	Yes	No	Yes	No	Yes	No

If the student is to have more than the recommended dose, please include written order from physician.

Has your child ever been diagnosed with the following, if so what and when?									
ADD	☐	ADHD	☐	Asthma	☐	Diabetes	☐	Seizures	☐
Vision Issues	☐	Hearing Issues	☐	Bladder/Kidney Issues	☐	Bone/Joint Issues	☐	Heart Trouble	☐
Dates of Diagnosis:									
Other Health issues:									

Does your child have allergies to medications, foods, the environment, etc.?	
Allergy	Reactions

Does your child take medications? ____ Yes ____ No If yes, what medication and dosage? _____

Does your child have a health condition that limits his/her activity? ____ Yes ____ No If yes, describe: _____

ALERT: Any medication requiring administration during school hours must be brought to the nurse in the original container. Signed and dated documentation from the health care provider is required along with the Medication Administration Form signed by the parent/guardian.

Signature of Parent/Guardian _____ Date: _____