

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: _____