

SCHOOL HEALTH INFORMATION

This information is essential for prompt and efficient care of each student

Student's name _____ DOB _____ Grade _____
Last First MI

Address _____

School _____ Teacher _____

Mother/Guardian Name _____ Father/Guardian Name _____

Mother/Guardian Home # _____ Work # _____ Cell # _____

Father/Guardian Home # _____ Work # _____ Cell # _____

1. List any medical conditions that are presently being monitored by a physician _____

2. List allergies (food, medication or seasonal) and type of reaction experienced _____

3. List current medications taken at home or school with the dosage and time _____

Please note that medication to be given at school requires a form signed by the parent/guardian and/or physician and must be brought to school by the parent/guardian in proper container. See student agenda for more details.

4. List surgeries and hospitalizations including dates _____

5. Date of Last Tetanus _____

6. List doctor's name and phone number, and hospital preference in case of emergency

_____ Doctor's name Phone Number Hospital

_____ Dentist's name Phone Number

7. Does student have health insurance? ____ Yes ____ No
If yes, Health Insurance Name _____ ID# _____ Group# _____

8. My child may be released to the following persons in case of an emergency or major disaster:

Name _____ Daytime phone _____ Cell _____

Name _____ Daytime Phone _____ Cell _____

Name _____ Daytime Phone _____ Cell _____

Name _____ Daytime Phone _____ Cell _____

Name _____ Daytime Phone _____ Cell _____

Out-of-State Contact

Parent/Guardian Signature _____ Date _____

THIS FORM MUST BE SIGNED AND TURNED IN TO YOUR SCHOOL NURSE