Confidential Health Information

Student Name _____ M ___ F ___

Grade _____ Age _____ Date of Birth _____

Father _____ Mother _____

Address _____ Address _____

City, State, Zip _____ City, State, Zip _____

Home Phone _____ Home phone _____

Work Phone _____ Work phone _____

Cell Phone _____ Cell phone _____

Emergency Contact Information

Name _____ Relationship _____

Phone _____ Work _____ Cell _____

Student Health Issues (Check all that apply)

- ☐ Vision problems
- ☐ Lung/Asthma/TB
- ☐ Blood Disease
- ☐ Hearing/Earaches
- ☐ Stomach/Ulcer
- ☐ Speech difficulty
- ☐ Headaches/Head Injuries
- ☐ Bone/Joint Disease
- ☐ Epilepsy
- ☐ Eating/Sleeping Problems
- ☐ Heart Condition
- ☐ Diabetes
- ☐ Other _____

If you have checked any of the above, please give a brief comment:

_____

Does your child have any significant allergies or sensitivities that you feel school personnel need to know about?

_____

Is your child under medical care? _____

Is your child on any medication? _____ Type: _____ Dosage: _____

Possible side effects: _____

Will the medication be taken at school? Yes ___ No ___ Time _____ ***(A permission slip signed by a physician must be on file for any and all OTC and prescription medications. Permission slips can be obtained at the front office.)***

If I cannot be reached by telephone in the event of an emergency involving my student, please send my child to any available medical service. If an ambulance service is necessary, parents must assume financial responsibility.

_____ _____

Signature of Parent of Guardian Date