

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

Speech difficulty

Heart Condition

Lung/Asthma/TB

Headaches/Head Injuries

Diabetes

Blood Disease

Bone/Joint Disease

Other _____

Hearing/Earaches

Epilepsy

Stomach/Ulcer

Eating/Sleeping Problems

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