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 is presently being monitored by a physician_______________
____
____

2. List allergies (food, medication or seasonal) and type of reaction experienced______________
____

NOTE: An additional form signed by a physician is required for food allergies, please see cafeteria manager for this.

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