2013-2014

SCHOOL HEALTH INFORMATION

Student # _____ Grade _____ Teacher/HR _____

Student _____, _____ Gender: M F DOB ___/___/_____
Last Name First Name

Address _____

Health History

ALLERGIES	□Yes	□No	PHYSICAL HANDICAPS	□Yes	□No
DIABETES	□Yes	□No	SEIZURE DISORDER	□Yes	□No
SICKLE CELL DISEASE	□Yes	□No	ASTHMA	□Yes	□No
CANCER	□Yes	□No	ADHD/ADD	□Yes	□No

If you answered *yes* to any of the above, please detail specifics in the space provided along with any other physical or mental health issues which may be a concern at school.

_____

_____

□ Does your child have any condition that would limit physical education activities? List _____
□ Does your child take any prescribed medication routinely? List _____

Do we have permission to complete Hearing and/or Vision Screenings on your child? □ Yes □ No

List name(s) of school-age siblings:
1. _____ Grade/School _____
2. _____ Grade/School _____
3. _____ Grade/School _____

Emergency Contact Information

Parent/Guardian #1 _____, _____ Relation _____
Last Name First Name
Home # ___/___/___ Work # ___/___/___ Cell # ___/___/___ E-mail_____

Parent/Guardian #2 _____, _____ Relation _____
Last Name First Name
Home # ___/___/___ Work # ___/___/___ Cell # ___/___/___ E-mail_____

If parents/guardians cannot be reached, list two persons who will assume care of your child.

Name _____ Relation _____ Phone ___/___/_____
Name _____ Relation _____ Phone ___/___/_____

Child's Healthcare Provider _____ Phone ___/___/_____

I give permission to give my child (check all that apply) □Tylenol □Advil □Caladryl/Calamine Lotion □Benadryl Cream □Tums (or generic equivalent) according to label instructions. □Yes □No (Box MUST be checked for medication administration – Parent will be contacted prior to administration.)
I also understand that, if in the event of an emergency, I cannot be reached, the school will have my child transported to the hospital via the EMS/911 service to receive appropriate treatment. □Yes □No

Parent Signature _____ **Date** _____