

2022 - 2023



# STUDENT HEALTH INFORMATION

THIS FORM MUST BE COMPLETED EACH SCHOOL YEAR.  
THIS INFORMATION MAY BE SHARED WITH OTHER SCHOOL STAFF AS NEEDED.

Student's Name \_\_\_\_\_ Gender M F Grade \_\_\_\_\_  
 Home Address \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Father's Name \_\_\_\_\_ Phone Number \_\_\_\_\_  
 Mother's Name \_\_\_\_\_ Phone Number \_\_\_\_\_  
 Student Lives With \_\_\_\_\_ Both Parents \_\_\_\_\_ Mother \_\_\_\_\_ Father \_\_\_\_\_ Guardian (Name \_\_\_\_\_)

### EMERGENCY CONTACTS (IN CASE PARENT/GUARDIAN CANNOT BE REACHED)

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone Number \_\_\_\_\_  
 Doctor \_\_\_\_\_ Phone Number \_\_\_\_\_  
 Dentist \_\_\_\_\_ Phone Number \_\_\_\_\_  
 Hospital Preference (in case of emergency) \_\_\_\_\_

### DOES YOUR CHILD HAVE:

### PLEASE EXPLAIN IF ANSWER IS YES

Allergies? (Food/Insects/Medication)  Yes  No List of allergies/reactions: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 If exposed, does your child need? (circle one)  
 Benadryl Epi-pen Both  
 Food allergy form on file with Child Nutrition? (circle one)  
 Yes No  
 Asthma/Reactive Airway Disease?  Yes  No Inhaler required at school? (circle one)  
 Yes No  
 Bladder/Bowel Problems?  Yes  No  
 (Parents will be called to change child if necessary.)  
 Blood or Clotting Disorder/Cancer?  Yes  No  
 Bone or Joint Problems?  Yes  No  
 Congenital (Birth) Defect(s)?  Yes  No  
 Diabetes/Blood Sugar Issues?  Yes  No Type: (circle one) 1 2  
 Insulin dependent? (circle one) Yes No  
 Recent Surgery?  Yes  No  
 Hearing Difficulty/Hearing Aid(s)?  Yes  No  
 Heart Disease or Defect?  Yes  No  
 Migraines/Headaches?  Yes  No Medication: \_\_\_\_\_  
 Seizures?  Yes  No Type: \_\_\_\_\_  
 Medication: \_\_\_\_\_  
 Date of last seizure: \_\_\_\_\_  
 Precautions/Restrictions? \_\_\_\_\_  
 Skin Problems/Rashes?  Yes  No  
 Stomachaches?  Yes  No Medication: \_\_\_\_\_  
 Vision Difficulties?  Yes  No Glasses or Contacts? \_\_\_\_\_  
 Does your child have health insurance?  Yes  No Name of Insurance Provider \_\_\_\_\_

### OTHER HEALTH CONCERNS (INCLUDING HOSPITALIZATION OR SURGERIES NOT MENTIONED)

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### IS THE STUDENT TAKING ANY MEDICATIONS AT HOME OR SCHOOL? PLEASE LIST AND EXPLAIN.

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Notice: In the event of illness or accident to our student, requiring immediate medical or dental attention, and if school authorities are unable to contact us, we hereby authorize and empower the principal, teacher or school nurse, acting as our agent and attorney-in-fact to secure immediate medical or dental attention from our family doctor/dentist acting in his absence, or the hospital or dental clinic we have listed. I know of no health reason(s), other than the information indicated on this form, why my child should not participate in any school activity.

Parent/Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_