Student Health Information

School Year 2016/2017

Grade: ________

Student ID: ________________

To be completed by the Parent/Guardian - Please Print Clearly

Student Last Name:	Student First Name:	
Address:	Birth Date	
City/State/Zip:	Gender: M ☐ F ☐	Primary Phone:
Mother's Name		Mother's Primary Phone
Father's Name:		Father's Primary Phone
Child resides with		

ANY MEDICATION, INCLUDING OVER-THE-COUNTER, SENT TO SCHOOL SHOULD FOLLOW DISTRICT GUIDELINES

Does your child have allergies? Yes ☐ No ☐	Please list:
Does your child have asthma? Yes ☐ No ☐	
Describe any health concerns or medical diagnoses:	
Please list any medication, doses, and time taken:	
Physician's Name:	Phone

If an emergency arises during my absence, I want my child to be given any medical treatment deemed necessary by the examining physician.

Signature of Parent/Legal Guardian: ______________________________ **Date:** ______________