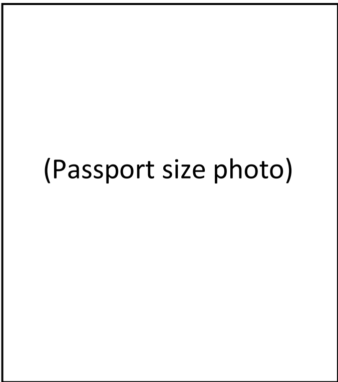

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HEALTH INFORMATION CARD

Full Name of Student: ____ Sex: _____ Grade: _____ School: ___________
(Last) (First) (Middle) (M/F)

Resident Address: ____

Mailing Address *(if different)*:____

Date of Birth: _____ / _____ / _____ Place of Birth: ____
City State Country

Name / Address of Person(s) with whom Student may reside:

	Name	Address *(If different than above)*	Home #	Work #	Mobile#
Father	______________________	____________________________	__________	__________	__________
Step-Father	__________________	____________________________	__________	__________	__________
Mother	______________________	____________________________	__________	__________	__________
Step-Mother	__________________	____________________________	__________	__________	__________
Guardian	____________________	____________________________	__________	__________	__________

Brothers/Sisters

Name __________________________________ Age ____________ School ___________________________

Name __________________________________ Age ____________ School ___________________________

Name __________________________________ Age ____________ School ___________________________

Name __________________________________ Age ____________ School ___________________________

Name __________________________________ Age ____________ School ___________________________

Name __________________________________ Age ____________ School ___________________________

Any legal restricted custody decision the school health office should be aware of? YES / NO

If Yes, describe: ____

Language(s) spoken by Student ____

Language(s) spoken at home ____

PLEASE CHECK THE FOLLOWIING ITEMS, IF THEY PERTAIN TO YOUR STUDENT:

◊ ADHD ◊ Allergies (drug) ◊ Allergies (food) ◊ Allergies (seasonal) ◊ Asthma ◊ Birth defects ◊ Birth disorder ◊ Bowel/bladder

◊ Diabetes ◊ Glasses/contacts ◊ Headaches/migraines ◊ Hearing problem ◊ Heart condition ◊ Orthopedic

◊ Psychiatric disorder ◊ Seizure disorder ◊ Other **(If any items were checked, please explain)** ___________________________

____

If your student is to take medication at school, a signed consent form is required.

Please list *all* medication(s) student is now taking at home or school: ____

What health or physical problem might affect school attendance or participation in PE? ______________________________

Has your student ever been involved in a special education program? If yes, please explain ____________________________

____

INSURANCE COVERAGE: YES / NO

If yes, please state Insurance Company's Name ____________________________

Doctor ______________________________ Phone ______________ Hospital Preference ____________________

If parent/ guardian cannot be reached, name a relative or friend with a LOCAL PHONE who will be responsible for your student if he/ she is hurt or becomes ill at school. (Please notify the school health office of any information changes on this card.)

Name ___________________________ Address ______________________________ Phone(s) __________________

Name ___________________________ Address ______________________________ Phone(s) __________________

Name ___________________________ Address ______________________________ Phone(s) __________________

If emergency medical action or treatment is required, and parent/ guardian cannot be contacted, I hereby authorize my child to be given emergency medical care as deemed necessary by school officials. I understand that any expenses incurred will be paid for by the parent/ guardian or by insurance coverage provided by the parent/ guardian, and that payment of any medical expense is not the responsibility of the school or the school district.

Parent/ Guardian Signature ____ Date ______________

(Signature verifies that all of the information on this card is accurate)