

School Year: _____

HEALTH & CONTACT INFORMATION FORM

(To be completed and returned to the School Nurse)

Student's Name: _____	DOB: _____
Grade/Teacher: _____	
Home Address: _____	Phone: _____
Mother/Guardian: _____	Cell: _____
Employment: _____	Work: _____
Father/Guardian: _____	Cell: _____
Employment: _____	Work: _____

PLEASE CHECK THE APPROPRIATE CONDITIONS OF YOUR CHILD: **NONE**

SEVERE ALLERGY (requiring Benadryl &/or EPI-PEN in school) _____

Asthma Diabetes Seizures Glasses Other (give details below) _____

Physical Limitation: _____

Please give details on any item that you checked above and anything else that you would like to bring to the attention of the School Nurse, Teacher, &/or Staff: _____

List any MEDICATION: _____

Reason for Medication: _____

**For medication in school, see School Nurse for medication policy and proper medication order/parent consent forms.*

Date of last Physical Exam: _____

Physician's Name & Telephone: _____

Date of last Dental Exam: _____

Dentist's Name & Telephone: _____

- I give permission to share above information with appropriate staff
- I DO NOT give permission to share above information with appropriate staff

RESPONSIBLE ADULTS WHO MAY BE CONTACTED & PICK UP YOUR CHILD IF YOU ARE UNAVAILABLE:

NAME: _____	Relationship to student: _____
Home Phone: _____	Work: _____ Cell: _____
NAME: _____	Relationship to student: _____
Home Phone: _____	Work: _____ Cell: _____
NAME: _____	Relationship to student: _____
Home Phone: _____	Work: _____ Cell: _____

Parent/Guardian Signature: _____ **Date:** _____

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