Annual Health & Emergency Information Form / 2018-2019

Student name:____________________________________ M / F Grade:__________ Date of Birth:______________
(First and Last)

Father/ Guardian Information:	Mother / Guardian Information:
Name:____	Name:____
Home Phone:___________________________________	Home Phone:___________________________________
Cell Phone:_____________________________________	Cell Phone:_____________________________________
Work Phone:____________________________________	Work Phone:____________________________________
Place of Employment:_____________________________	Place of Employment:_____________________________
E-Mail Address:__________________________________	E-Mail Address:__________________________________

Emergency Contact:___________________________ Relationship:_________ Phone Number:____________________

Emergency Contact:___________________________ Relationship:_________ Phone Number:____________________

Health History ✓ Check all conditions your child currently has or has been treated for in the past

ADHD / ADD		Ears / Eyes / Nose Problems		___ **Other**:_______________________
Allergies – Epi in school Y / N		Epilepsy / Seizures		__________________________________
Anxiety / Depression		Migraines (diagnosed by MD)		__________________________________
Asthma - Inhaler at school Y / N		Nose Bleeds (frequent)		__________________________________
Diabetes		Restrictions of Activity		__________________________________
Digestive Problems		Skin Conditions		

Eye Glasses or Contacts Y / N	**Ear Tubes Y / N**	**Hearing Aides Y / N**

Medications: Does your child take any medications or treatments? All medication given at school must have a written prescription or signed Medication Administration Form (MAF) before school staff can administer it. ALL medications need to be in the original container.

	Medication / Treatment	**Purpose**
Home		
School		

Doctor	**Clinic**	**Phone Number**

In case of an accident or serious illness, I request the school contact me. If the school is unable to reach me, I hereby authorize the school to call the physician indicated and to follow his / her instructions. If it is impossible to contact the physician, the school may make whatever arrangements seem necessary. I will not hold the school district responsible for the emergency care and / or transportation for my child.
Your signature also indicates permission to share health information with appropriate medical, school, and other support staff (food & bus service), as necessary.

Parent Signature:____ Date:_____________________