

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: _____

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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
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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: _____