Annual Health & Emergency Information Form / 2025-2026

Student name: _____ Grade: _____ Date of Birth: _____
(First and Last)

Mailing Address: _____ Physical Address: _____

Parent/ Guardian Information:	Parent / Guardian Information:
Name: _____	Name: _____
Cell Phone: _____	Cell Phone: _____
Work Phone: _____	Work Phone: _____
Place of Employment: _____	Place of Employment: _____
E-Mail Address: _____	E-Mail Address: _____

Sibling & DOB: _____ Sibling & DOB: _____ Sibling & DOB: _____

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		Epilepsy / Seizures		_____
Anxiety / Depression		Migraines (diagnosed by MD)		_
Asthma		Nose Bleeds (frequent)		
Diabetes		Restrictions of Activity		
Digestive Problems		Skin Conditions		**Epi Pen in school: Y / N** **Inhaler in school: Y / N**

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

As part of our commitment to student health and academic success, routine hearing and vision screenings are conducted during the school year in accordance with state and district guidelines. These screenings are not diagnostic but are intended to identify potential concerns that may require further evaluation by a healthcare provider.

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:** _____