

# Annual Health & Emergency Information Form / 2020 2021

Student name: \_\_\_\_\_ M / F Grade: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
(First and Last)

Address: \_\_\_\_\_ Mailing Address: \_\_\_\_\_

Mother / Guardian Information:	Father / 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: _____

Siblings: \_\_\_\_\_

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	___ High risk health related to COVID-19 <b>Y / N</b> Contact School Nurse  <b>Epi Pen in school:    Y / N</b> <b>Inhaler in school:    Y / N</b>
Allergies	Epilepsy / Seizures	
Anxiety / Depression	Migraines (diagnosed by MD)	
Asthma	Nose Bleeds (frequent)	
Diabetes	Restrictions of Activity	
Digestive Problems	Skin Conditions	

Eye Glasses or Contacts <b>Y / N</b>	Ear Tubes <b>Y / N</b>	Hearing Aides <b>Y / N</b>
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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
<b>Home</b>		
<b>School</b>		

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: \_\_\_\_\_