Annual Health & Emergency Information Form / 2026-2027

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

Mailing Address:_____ Physical Address:_____

Parent/ Guardian Information	**Parent / 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:_____

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)		**Epi Pen in school: Y / N**
Asthma		Nose Bleeds (frequent)		**Inhaler in school: Y / N**
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**
School/ Home		

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:_____