Student Health & Emergency Information Sheet 2021-2022

Student Name:_______________________________________ Home School ______________________

Address:____
Street City State zip

Grade:__________ Age:_________ Date of Birth: ___________

Mother/Parent/Guardian (1) Name: ____

_________________ _____________________ _____________________
Home Phone Work Phone Cell Phone

Father/Parent/Guardian (2) Name: ____

_________________ _____________________ _____________________
Home Phone Work Phone Cell Phone

Does Student Reside With You? Yes ___ No ___ Do you have Custody? Yes ___ No ___

Parent /Guardian EMAIL: ____

I authorize the following individuals to pick-up ___________________ from school if a parent /guardian
Student's Name
is not available:

____
Name Relationship to Student Phone

____
Name Relationship to Student Phone

EMERGENCY CONTACTS

It is vitally important that we have names of at least two (2) individuals whom we can call in the event of an emergency and when we are unable to contact you.

1st Contact: _____________________________________ Relationship: ______________________
Phone: _______________________ (home) Phone: _____________________ (work)
Phone: _______________________ (cell)

2nd Contact: _____________________________________ Relationship: ______________________
Phone: _______________________ (home) Phone: _____________________ (work)
Phone: _______________________ (cell)

3rd Contact _____________________________________ Relationship: ______________________
Phone: _______________________ (home) Phone: _____________________ (cell)

PLEASE COMPLETE HEALTH AND MEDICAL INFORMATION ON PAGE TWO.

Parent/Guardian Signature: _________________________________ **Date:**_____________

OFFICE USE ONLY: Program_______________________Instructor______________________ am____ pm_____

Student Health & Emergency Information Sheet – page two

HEALTH HISTORY

Please check below any condition __currently__ affecting your child *(detail below as needed)***:**

☐ Drug Allergy	☐ Asthma	☐ Heart Condition	☐ Recent Injury/Hospitalized
☐ Insect Allergy	☐ Uses an Inhaler	☐ Vision Problems	☐ Mental Health Condition
☐ Food Allergy	☐ Kidney Disease	☐ Hearing Problems	☐ Wears Glasses/Contacts
☐ Environmental Allergy	☐ Seizure Disorder	☐ Depression/Anxiety	☐ ADD/ADHD
☐ Has an Epipen	☐ Diabetes	☐ Back Injury/Disorder	☐ Autism Spectrum Disorder
☐ Concussion	☐ Other: ______________________________		

Please list and explain any items checked above. Detail any additional illnesses, injuries and health problems your child has or is currently being treated for: ____

____

____

MEDICATIONS

Place check mark next to applicable:

_____ No Medications Taken _____ Receives Medication at Home _____ Receives Medication at School

Please list all medications taken on a regular basis:

Medication	Dosage/Frequency	Time Received	Reason
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

MEDICAL INFORMATION

Date of Last Tetanus Shot: __________________________ Hospital Preference:________________________

Insurance Provider: __________________________________ Insurance/Medicaid #: _______________________

Please list ALL doctors involved with your child, and their specialty (e.g. dentist, neurologist, cardiologist, dermatologist and etc.).

Doctor's Name	Specialty	Address	Phone	Date Last Seen