

# Student Health & Emergency Information Sheet 2020- 2021



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 is not available:  
Student's Name

Name	Relationship to Student	Phone
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Name	Relationship to Student	Phone
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## 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.

1<sup>st</sup> Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Phone: \_\_\_\_\_ (home) Phone: \_\_\_\_\_ (work)  
Phone: \_\_\_\_\_ (cell)

2<sup>nd</sup> Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Phone: \_\_\_\_\_ (home) Phone: \_\_\_\_\_ (work)  
Phone: \_\_\_\_\_ (cell)

3<sup>rd</sup> 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 \_\_\_\_\_

**HEALTH HISTORY**

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

- |                                                |                                           |                                               |                                                     |
|------------------------------------------------|-------------------------------------------|-----------------------------------------------|-----------------------------------------------------|
| <input type="checkbox"/> Drug Allergy          | <input type="checkbox"/> Asthma           | <input type="checkbox"/> Heart Condition      | <input type="checkbox"/> Recent Injury/Hospitalized |
| <input type="checkbox"/> Insect Allergy        | <input type="checkbox"/> Uses an Inhaler  | <input type="checkbox"/> Vision Problems      | <input type="checkbox"/> Mental Health Condition    |
| <input type="checkbox"/> Food Allergy          | <input type="checkbox"/> Kidney Disease   | <input type="checkbox"/> Hearing Problems     | <input type="checkbox"/> Wears Glasses/Contacts     |
| <input type="checkbox"/> Environmental Allergy | <input type="checkbox"/> Seizure Disorder | <input type="checkbox"/> Depression/Anxiety   | <input type="checkbox"/> ADD/ADHD                   |
| <input type="checkbox"/> Has an EpiPen         | <input type="checkbox"/> Diabetes         | <input type="checkbox"/> Back Injury/Disorder | <input type="checkbox"/> Autism Spectrum Disorder   |
| <input type="checkbox"/> Concussion            | <input type="checkbox"/> 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