SCHOOL HEALTH FORM #5

Schools that do not use the local county public health record form should use Form #5, the School Health Form. The purpose of this form is to record pertinent and helpful health information so that teachers may be better able to help each pupil. Immunizations required by State law should be indicated; emergency contact information should also be recorded on the form.

The School Health Form is begun as soon as a pupil is placed on roll and information is cumulated as the pupil continues in the school.

School Health Form #5 or local county public health record should be retained in the school. When a pupil transfers to another school, the public health record should follow the student. Upon graduation from high school, the record is destroyed.

Whichever form is utilized, the following information should be included:

1. Student Full Name
2. Student Address
3. Physician's Name
4. Physician's Phone Number
5. Health Insurance (Company Name)
6. Hospital Preference
7. Medical History – indicating any of the following:
   a. Fainting Spells
   b. Epilepsy
   c. Diabetes
   d. Allergies
   e. Other
   f. Serious Illness or Injuries
   g. Medicine taken on a daily basis
8. Emergency Information
   a. Father/Guardian Name and Mother/Guardian Name
   b. Father/Guardian Home Phone # and Mother/Guardian Home Phone #
   c. Father/Guardian Work Phone # and Mother/Guardian Work Phone #
   d. Father/Guardian Pager # and Mother/Guardian Pager #
   e. Father/Guardian Cell Phone # and Mother/Guardian Cell Phone #
   f. Alternate contacts if parents/guardians not available.
      i. Name
      ii. Relationship
      iii. Phone #
9. Statement signed and dated by Parent/Guardian providing consent for treatment of the pupil by a physician, selected by school officials or those persons conducting or assisting in any school related function or activity, or hospital emergency room personnel when the Parent/Guardian is unavailable. (Sample of Form #5 follows.)

SCHOOL HEALTH FORM

Student Name ______________________________ Student Address ______________________________

Name of School ____

Physician Name ____________________________ Physician Phone #______________________________

Health Insurance (Company Name) ____

Hospital Preference ____

MEDICAL HISTORY:	YES	NO	REMARKS
Fainting Spells			
Epilepsy			
Diabetes			
Allergies			
Other			
Serious Illness or Injuries			

Please list any medicine student takes on a daily basis.

Emergency Information for: ____
(Name of Student)

Father/Guardian Name ______________________ Mother/Guardian Name ____________________

Father/Guardian Home Phone # _________________ Mother/Guardian Phone # ____________________

Father/Guardian Work Phone #_________________ Mother/Guardian Work Phone #________________

Father/Guardian Pager # ______________________ Mother/Guardian Pager # ____________________

Father/Guardian Cellular Phone # _______________ Mother /Guardian Cellular Phone # _____________

In case of an emergency, if parent/guardian is not available, please notify:

Name ____________________ Relationship ________________ Phone # ____________________

Name ____________________ Relationship ________________ Phone # ____________________

In the event of illness and the unavailability of the above named physician, I consent to the treatment of my child by a physician, selected by school officials or those persons conducting or assisting in any school related function or activity, or hospital emergency room personnel. This consent shall remain in full force and effect so long as my child is a student at the school unless notice or revocation is given in writing to the Principal of this school.

Parent/Guardian Signature ______________________________ Date ________________