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 ______________________