

School Year: _____

HEALTH & CONTACT INFORMATION FORM

(To be completed and returned to the School Nurse)

Student's Name: _____ DOB: _____
Grade/Teacher: _____
Home Address: _____ Phone: _____
Mother/Guardian: _____ Cell: _____
Employment: _____ Work: _____
Father/Guardian: _____ Cell: _____
Employment: _____ Work: _____

PLEASE CHECK THE APPROPRIATE CONDITIONS OF YOUR CHILD: ☐ **NONE**

- ☐ SEVERE ALLERGY (requiring Benadryl &/or EPI-PEN in school) _____
☐ Asthma ☐ Diabetes ☐ Seizures ☐ Glasses ☐ Other (give details below)
☐ Physical Limitation: _____

Please give details on any item that you checked above and anything else that you would like to bring to the attention of the School Nurse, Teacher, &/or Staff: _____

List any MEDICATION: _____
Reason for Medication: _____

**For medication in school, see School Nurse for medication policy and proper medication order/parent consent forms.*

Date of last Physical Exam: _____
Physician's Name & Telephone: _____

Date of last Dental Exam: _____
Dentist's Name & Telephone: _____

- ☐ I give permission to share above information with appropriate staff
☐ I DO NOT give permission to share above information with appropriate staff

If it is necessary for us to transport your child to a hospital and we are unable to reach you, may we do so? ☐ Yes ☐ No

RESPONSIBLE ADULTS WHO MAY BE CONTACTED & PICK UP YOUR CHILD IF YOU ARE UNAVAILABLE:

NAME: _____ **Relationship to student:** _____
Home Phone: _____ **Work:** _____ **Cell:** _____

NAME: _____ **Relationship to student:** _____
Home Phone: _____ **Work:** _____ **Cell:** _____

NAME: _____ **Relationship to student:** _____
Home Phone: _____ **Work:** _____ **Cell:** _____

Parent/Guardian Signature: _____ **Date:** _____