Ambassadors Preparatory Academy

School Health Services

___Grade
Home Room Teacher
_____

Previous School Attended:_____

Please complete in print and return to school nurse as soon as possible.

Student's First Name:	Middle Name:		Date of Birth:
Home Address:	City:		Zip:

TELEPHONE NUMBERS WHERE PARENT/GUARDIAN CAN BE REACHED IN CASE OF EMERGENCY		
Home Phone Number:	Mother's Work Number:	Father's Work Number:
Other Contact Name:	Relation To Student:	Number:
Other Contact Name:	Relation To Student:	Number:

PLEASE INDICATE BY CHECKING AND/OR EXPLAINIG IF THE STUDENT CURRENTLY HAS OR PREVIOUSLY EXPERIENCED ANY OF THE FOLLOWING	
Allergies to any foods or medications: Yes No	If Yes, explain allergies, reactions and treatment:
Tuberculosis: Yes No	If Yes, list dates of contact with any active case:

Asthma: Yes No	Cardiac: Yes No	Diabetes: Yes No	Rheumatic Fever: Yes No
Hearing Problems: Yes No	Vision Problems: Yes No	S eizures: Yes No	Frequent Dizziness: Yes No
Frequent Fainting: Yes No	Convulsions: Yes No	Tremors: Yes No	

Please explain any Yes answers above:

Does the student take any medication? Yes No	If Yes, for what reason?_____ What is the dosage? _____ How often is medication taken?_____	
Name of Student's Physician:	Physician's Phone Number:	Has student had a physical exam in the past? Yes No

EMERGENGY-MEDICAL CARE

I give permission for my child _____ to be given emergency
(print student's name)
Medical or surgical management (including diagnostic studies and treatment) at an Emergency Room in the event that a parent or guardian cannot be located.

Please check hospital preference: UTMB___ Other___ Name:_____

_____ _____
Parent/Guardian Signature Date