STUDENT HEALTH RECORD
2015 - 2016 School Year
** PLEASE COMPLETE ALL BLANKS**

NAME_____ **F** **M** _____ _____ GRADE _____
LAST FIRST MI (CIRCLE ONE) DATE OF BIRTH

PLEASE LIST ALL ALLERGIES:_____

_____

ADDRESS_____CITY_____STATE_____ ZIP _____

1st CONTACT_____
Name Phone Number

2nd CONTACT_____
Name Phone Number

MUST HAVE EMERGENCY NAMES & PHONE #S WHEN YOU CANNOT BE REACHED!!!

3rd CONTACT_____

CHILD'S DOCTOR & PREFERRED HOSPITAL _____

In an emergency your child will be taken to nearest hospital determined by EMS personnel. EMS will be given your hospital preference.

HEALTH PROBLEMS (PHYSICIAN DIAGNOSIS)

VISUAL PROBLEMS: Y / N GLASSES / CONTACTS

HEARING PROBLEMS: Y / N HEART DISEASE: Y / N

ASTHMA: Y / N INHALER / NEBULIZER TREATMENTS_____

DIABETES: Y / N ORTHOPEDIC: Y / N

CHRONIC HEADACHES: Y / N SEIZURES: Y / N

MEDICATIONS YOUR CHILD TAKES DAILY OR AS NEEDED: _____

HEALTH HISTORY

WAS THERE A DELAY IN YOUR CHILD'S GROWTH OR DEVELOPMENT (WALKING, TALKING, ECT.)? Y_____ N_____

IF SO PLEASE EXPLAIN: _____

DISEASE HISTORY (GIVE DATES); N/A IF NOT APPLICABLE

RHEUMATIC FEVER: Y / N MUMPS: Y / N CHICKEN POX: Y / N SCARLET FEVER: Y / N

GERMAN MEASLES Y / N CHRONIC EAR INFECTION: Y / N MEASLES: Y / N

KIDNEY INFECTIONS: Y / N IMMUNODIFFENCY: Y / N

OTHER HEALTH PROBLEMS NOT LISTED

_____

_____

EMAIL ADDRESS: _____

SIGNATURE OF PARENT/GUARDIAN: _____

DATE