STUDENT HEALTH INFORMATION SHEET

School Year: _____

MEDICAL CONDITION: _____

(This form will be made available to teachers and appropriate school staff.)

Place Student's Picture Here

Student's Name: _____

DOB: ___/___/_____ **Allergies:** _____

School: _____ Teacher: _____ Grade: _____

Bus Rider: ☐ Yes ☐ No Bus #: AM_____ PM_____ Non-Transported ☐

Parent/Guardian(s) Name(s): _____

Address/Zip Code: _____

Call Parent/Guardian 1: – Home: _____ Work: _____ Cell: _____

Call Parent/Guardian 2: – Home: _____ Work: _____ Cell: _____

Alternate contact person in case of emergency:

Name: _____ Relationship: _____ Phone: _____

PHYSICIAN'S NAME: _____ PHONE: _____

HOSPITAL OF CHOICE: _____

HISTORY OF MEDICAL CONDITION - Include date of onset and most recent concerns: _____

_____

_____

* MEDICATIONS & TREATMENTS AT SCHOOL: _____

_____

_____

ADDITIONAL COMMENTS: _____

_____

_____

[ ]

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____/_____/_____

Must complete Medication Consent Forms prior to any prescription medications being brought to school to be administered. Forms are available at school.

REVIEWED BY: _____***, RN*** ***DATE:*** _____/_____/_____