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**

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:** _____