STUDENT HEALTH AND EMERGENCY INFORMATION- One per student

Student LAST Name:	Student FIRST Name:	Date of Birth:
Grade in the fall:	Home #: ( )	
Home Address:	City:	Zip:

Mother's full name:	Email:	Cell #:	Work#:
Father's full name:	Email:	Cell#:	Work#:

Physician:	Physician's Phone Number:

EMERGENCY CONTACTS- If parent is not available. List in order of Preference

Name:	Relationship	Home Phone	Cell Phone	Work Phone:
1.				
2.				

MEDICAL CONDITIONS: Check all that apply

		ALLERIGIES:	MEDICATIONS:
☐ 504 B Plan ☐ ADD/ADHD ☐ Anxiety ☐ Asthma – Please Explain Below ☐ Cardiac Condition ☐ Concussion: list date/s below ☐ Diabetes – Please Explain Below ☐ Broken Bones ☐ Ear/Hearing ☐ Eye/Vision ☐ Contacts/Glasses	☐ Stomach Issues ☐ Headaches ☐ Hyper/Hypo thyroid ☐ Migraine ☐ Mobility Impairment ☐ Fainting ☐ Nose Bleeds ☐ Seizures ☐ Surgeries ☐ Other	☐ Bee/Wasp sting ☐ Eggs ☐ Fruit ☐ Latex ☐ Dairy ☐ Peanut ☐ Shellfish ☐ Soy ☐ Tree Nut ☐ Other **Describe Allergy Reactions and Medications Below**	☐ Epipen ☐ Benadryl ☐ Rescue Inhaler ☐ Other-please list

Other:

Parent Signature: Date:

Revised 6/16