



Student Contact Information

Last Name, First Name _____ Grade _____ DOB: _____
(mm/dd/yyyy)

Student lives with ___ both parents ___ Mom ___ Dad ___ Other: _____

Mom home phone _____ Mom cell _____ Mom work _____

Dad home phone _____ Dad cell _____ Dad work _____

Doctor _____ Dentist _____ Orthodontist _____

Phone _____ Phone _____ Phone _____

General Health

_____ My child has no known health conditions.

_____ My child has a history of the following health condition(s). Check all that apply, and complete a treatment plan form for each. (Nurse will provide)

_____ Allergies	_____ Asthma	_____ Diabetes
_____ Seizure disorder	_____ Hemophilia	_____ Cancer
_____ Heart condition	_____ Physical disability	_____ Other

Medications

_____ My child needs to take medication while at school.

Medications to be given at school:
*Must be supplied by the parent in the original packaging, trial size if possible.
*Must be accompanied by a Medication Permission Form (on website under "Nurse")

_____ My child takes medications at home. (Medication names and dosages)

Parent's signature: _____ Date _____

- Non health care personnel may assist students in the self administration of medications.
- If emergency treatment is required, and parents cannot be reached immediately, your signature above allows for the transport to the nearest hospital emergency department.

Date _____

Notes: _____

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