

Health History and Contact Information
School Year 2006-2007

STUDENT'S NAME Last _____ First _____ MI _____
GRADE _____ TEACHER _____
DATE OF BIRTH (MONTH, DAY, YEAR) _____ / _____ / _____
SPONSOR'S NAME Last _____ First _____
RANK _____ WORK PHONE _____ Ext _____
SPOUSE'S NAME Last _____ First _____
IF EMPLOYED, PLACE OF EMPLOYMENT _____
SPOUSE'S WORK PHONE _____ Ext _____
HOME PHONE _____
PAGER NUMBER _____
CELLULAR PHONE NUMBER _____
E-MAIL ADDRESS *if you wish to be contacted by e-mail.*
Mother at work _____
Father at work _____
Home _____

IT IS IMPERATIVE THAT WE HAVE THE LOCAL PHONE NUMBER OF A FRIEND OR NEIGHBOR, *SOMEONE OTHER THAN A PARENT*, WHO COULD TAKE CHARGE OF YOUR CHILD IN CASE OF AN ILLNESS OR EMERGENCY IF WE ARE UNABLE TO REACH YOU. IT IS RECOMMENDED THAT THESE CONTACTS HAVE A MEDICAL POWER OF ATTORNEY TO ENSURE MEDICAL CARE.

1. Name _____
Address _____ Phone _____
2. Name _____
Address _____ Phone _____

DOES YOUR CHILD TAKE MEDICATION?

Name of medication(s) _____
Taken for _____
Taken when _____

Has your child ever had an allergic reaction to medicine? _____
If yes, what medicine? _____
What kind of reaction? _____
What, if any, medical care was needed for the reaction? _____

Has your child been hospitalized for any reason since birth? _____
If yes, explain _____

PLEASE COMPLETE REVERSE

PLEASE CIRCLE AND EXPLAIN THE ITEMS THAT APPLY TO YOUR CHILD

ASTHMA

When was the last episode that required hospitalization? _____

ALLERGY

Allergic to _____

BEE STING ALLERGY

Has it ever required hospitalization or treatment by a physician? _____

BIRTH INJURIES _____

CHICKENPOX (if so, date) _____

DIABETES _____

HEART _____

JOINTS/BONES _____

KIDNEY INFECTION _____

NEUROMUSCULAR _____

SEIZURE DISORDER (CONVULSIONS) _____

REPEATED SINUSITIS _____

STREPT THROAT _____

EAR INFECTIONS _____

VISION PROBLEMS _____

GLASSES _____

HEARING PROBLEMS _____

HEARING AIDES _____

DOES THIS CHILD HAVE ANY OTHER HEALTH CONDITION THAT MAY AFFECT SCHOOL WORK, ATTENDANCE, OR SCHOOL ACTIVITIES?

If yes, please explain: _____

IS THERE ANYTHING MORE ABOUT THIS CHILD'S HEALTH THAT YOU THINK IS IMPORTANT FOR US TO KNOW?

If yes, please explain: _____

IS THERE ANYTHING ABOUT THE HEALTH OF THIS CHILD THAT YOU WOULD LIKE TO DISCUSS IN PERSON OR BY PHONE ?

Parent Signature _____ **Date** _____

MEDICATION AT SCHOOL

Students may not carry medication on their person during the school day. Any medication to be taken at school must be kept in the school clinic. Only medication sent from home is kept at school. The school system does not stock Tylenol for general use by students.

If your child must take medication at school, you must send it in the original container. The container must be labeled with current and accurate information. You must complete a yellow medication form for each medication that will be administered at school. Forms are available at the school clinic. If pills need to be given as halves, please split them at home before sending them to school.