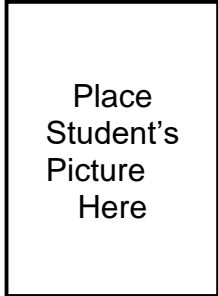


STUDENT HEALTH INFORMATION SHEET

School Year: _____

MEDICAL CONDITION: _____

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



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:** ____/____/____