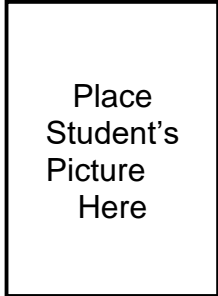


# STUDENT HEALTH INFORMATION SHEET

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: \_\_\_\_\_

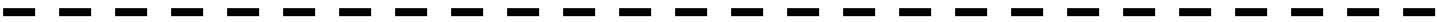
\_\_\_\_\_  
\_\_\_\_\_

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: \_\_\_/\_\_\_/\_\_\_