
# Health and Emergency Information

Student Name _____ DOB _____

Grade _____ Class _____

Parents' Names _____

Address _____

Cell Phone _____ Cell Phone _____

Father's Work _____ Mother's Work _____

Emergency Contact Name _____ Phone Number _____

Physician's Name _____ Phone Number _____

Hospital Preference _____

Diagnoses _____

Allergies _____

Medications taken at home _____

Medications taken at school _____

PLEASE LET YOUR STUDENT'S TEACHER AND/OR THE SCHOOL NURSE KNOW IN WRITING DURING THE YEAR IF THERE ARE ANY MEDICATION CHANGES OR NEW DIAGNOSES.

Diet Restrictions: Yes _____ No _____ If yes, Explain _____

Activity Restrictions: Yes _____ No _____ If yes, Explain _____

Walks Independently: Yes _____ No _____ If no, Explain _____

If your student is unable to be tested for vision or hearing at school, please provide the following:

Last private vision screening: _____ Results _____

Last private hearing screening: _____ Results _____

Last dental appointment date: _____ Results _____

Any hospitalizations, surgeries, or trips to the ER within the last year? If so, please explain:

_____

Has your child been seen by any medical specialists within the last year? If yes, please list with brief description of results: _____

Other medical information: _____

**NOTE: If your student has medical conditions (such as seizures, life threatening allergies, asthma, diabetes and/or requires services such as medication at school, G-tube feedings, tracheostomy care, etc.) a separate health plan and health care provider's orders are required to be updated every school year. Please contact the school nurse for specific instructions and required forms to be completed in place by the first day of school.**