



# Student Health Information Form

Entering Grade: \_\_\_\_\_

Gender: \_\_\_\_\_

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Home Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

Date of Last Physical Exam: \_\_\_\_\_

***IF THE ANSWER TO ANY OF THE FOLLOWING QUESTIONS IS “YES,” PLEASE DESCRIBE:***

1. Has your child had any serious illness, injury, or operation? \_\_\_\_\_  
\_\_\_\_\_
2. Have any tests, immunizations, or medications caused any reaction? \_\_\_\_\_  
\_\_\_\_\_
3. Does your child have eczema or any other skin disorder? \_\_\_\_\_  
\_\_\_\_\_
4. Is there any disorder of vision, hearing, or speech? \_\_\_\_\_  
\_\_\_\_\_
5. Is your child presently taking any prescription medication such as insulin, sedatives, anti-convulsing drugs, tranquilizers? \_\_\_\_\_  
\_\_\_\_\_
6. Is there any physical defect which limits participation in:
  - a. Classroom activities \_\_\_\_\_
  - b. Physical Education \_\_\_\_\_
  - c. Competitive Athletics \_\_\_\_\_
7. Is there any emotional, mental, or physical condition for which your child is under regular or periodic medical observation? \_\_\_\_\_  
\_\_\_\_\_
8. Is your child subject to any condition which may result in a classroom emergency; i.e., epilepsy, fainting, diabetes, allergies (bee sting, nuts), clotting time, heart disease? \_\_\_\_\_  
\_\_\_\_\_

***IF THE ANSWER TO #8 IS “YES,” PLEASE HAVE YOUR PHYSICIAN WRITE OUT THE ORDERS TO BE FOLLOWED IN CASE OF AN EMERGENCY DURING SCHOOL HOURS AND ENCLOSE THESE DIRECTIONS WITH THIS FORM.***

Date: \_\_\_\_\_ Parent Signature: \_\_\_\_\_