HEALTH INFORMATION DATE________________

Student's Name:________________________________ Date of Birth:___/_______/_____

Parent/Guardian Name:____

Address, City, State, Zip Code:____

Home Phone/VP: (______)____________________Work Phone:(____)___________

E-mail or Pager Address: ____

2nd Emergency Contact Person **(required)**: ___________________________________
Phone #: (______)___________________ Other Phone #: (_____)_____________

3rd Emergency Contact Person **(required)**: ___________________________________
Phone #: (______)___________________ Other Phone #: (_____)_____________

Health Insurance:_______________________ Policy Number:______________
(Please enclose a copy of current insurance card)

Current Health Conditions:____

Current Medications: ____

Current Emotional/Behavioral Concerns: ______________________________________

Does your child have seizures?_______ Type, Frequency, Duration:________________

Important information about your child______________________________________

Immunizations up-to-date? ❑ Yes ❑No (**Please attach immunization record**)

Allergies (list foods, medications, environmental, etc and reaction symptoms.):________
____
____

Family Doctor's Name: ___________________ Phone Number: (______)____________