Student Health Information Form

PLEASE COMPLETE THE FOLLOWING INFORMATION:

Student's Name _____ _____ _____
Last Name *First Name* *Middle Initial*

Social Security Number _____ **Birthdate** _____

School _____ **Grade** _____

Parent/Guardian Name _____ _____ _____
Last Name *First Name* *Middle Initial*

Mailing Address _____ _____ _____ _____
Street Address/Apt. # *City* *State* *Zip Code*

Telephone: Home: _____ **Work:** _____

E-mail Address: _____

Emergency Contact and Telephone Number _____

Family Physician _____ **Phone** _____

Medication Allergies: ☐ **Yes** ☐ **No** **List:** _____

_____

Other Allergies: ☐ **Yes** ☐ **No** **List:** _____

_____

Bee Sting Allergies: ☐ **Yes** ☐ **No** **Treatment/Medication:** _____

_____

Asthma: ☐ **Yes** ☐ **No** **Factors that may cause an attack:** _____

_____

Treatment/Medication: _____

_____

Seizures: ☐ **Yes** ☐ **No** **Type:** _____

Treatment/Medication: _____

_____

Diabetes: ☐ **Yes** ☐ **No** **Treatment/Medication:** _____

_____

Other Health Problems: _____

_____

Review/Revised:8/8/01