2020-2021 Health Information Form

Student ____ Grade Level/Teacher _____________________

Address ____ City _________________ Zip ______________

Gender ______________ DOB_________________

Type of Health Care Insurance: Medicaid____ PeachCare ____ Other____________

Health History (Please Check All That Apply)

_______ Asthma	_______ Seizures/Epilepsy	_______ Cystic Fibrosis	_______ ADD/ADHD
_______ Heart Problems	_______ Kidney Problems	_______ Bleeding Tendencies	_______ Depression
_______ Sickle Cell Disease	_______ Stomach Problems	_______ Frequent Nose Bleeds	_______ Other Behavior Problems
_______ Headaches	_______ Skin Disorders	_______ Diabetes	_______ Impaired Mobility
_______ Cochlear Implants	_______ Blindness	_______ Deafness	

List other medical problems

____

Please list any recent surgeries or hospitalizations

____

Please list any medications your child routinely takes and times

____

Child's Healthcare Provider_____________________________________ Phone______________________

Child's Dentist____ Phone______________________

Allergies

Is your child allergic to any medications? ___________

Please Describe ____

Does your child have any food allergies? ___________

Please Describe ____

Has your child had an allergic reaction to any bee/insect stings? If yes, what type of reaction occurs?

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Will your child need an Epi-pen at school? ___________

Emergency Contact Information

____________________ Name ___________________________________ Phone _____________________
relationship

Phone(Work) _____________________ E-mail address____

____________________ Name ___________________________________ Phone _____________________
relationship

Phone(Work) _____________________ E-mail address____

If parents cannot be reached, list four persons who will assume care of your child.

Name	Relationship	Phone Number

Does your child participate in an off-campus daycare or afterschool program? ______________
If yes,
facility Name____

Phone Number_______________________
Please make sure that you provide the facility with a car rider tag and a current school calendar so they are aware of holidays and half days

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Are there custody issues that the school should be aware of ? _______________

If yes, give a brief explanation. (Please note that all student records are kept confidential.)

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Non-Emergency Treatment/First Aid

Provide treatment needed: ______________

If you answered no, wait for approval of treatment by: ___Parent/Guardian ___Emergency Contact

Authorization for Emergency Treatment

In case of serious illness/injury, the school will telephone Emergency Medical Services (911) for immediate transportation to the nearest hospital. I, the parent/legal guardian, authorize the transport of and treatment by the hospital emergency staff for my child.

Fees for transportation and medical services will be the responsibility of the parent/guardian.

Parent/Guardian Signature____

Date_________________________