

School Health Information 2010 - 2011

Name of student _____ Date of Birth _____
(Last) (First) (M.I.)

Name of School _____ Teacher _____

Name of Parent/Legal Guardian _____

Home phone _____ Work phone Mother _____ Father _____
Cell phone Mother _____ Father _____

Emergency Contact _____ Phone _____

Health Information

Name of doctor _____ Phone _____

Name of dentist _____ Phone _____

Please list any health or medical problems your student has

Does your student require medication and/or treatments on a continuing basis? Yes ___ No ___

If yes, specify medicine or treatment _____

To be given at school? Yes ___ No ___

(IF YES, School requires written authorization and parent must transport)

Allergies (medicine, food, insect bites, other) _____

Has your student had any immunization in the past year? Yes ___ No ___ Name _____

Insurance

Does student have health insurance? Yes ___ No ___

Name of insurance provider _____
(Anthem, Medicaid, Virginia Premier, Famis, etc.)

I understand that it is my responsibility to keep school authorities informed regarding whom to contact in the event of my student becoming ill or injured at school. I understand that if I cannot be reached in an acute emergency my student will be taken to the emergency room of the nearest hospital.

Parent/ Guardian Signature _____ **Date** _____