

Grade _____

HEALTH INFORMATION CARD

Teacher _____

Student _____ Birth Date _____ Sex M F Age _____ Home Phone _____

Address _____ City _____ E-Mail _____

Sibling/Grade _____ Sibling/Grade _____ Mom Cell Phone _____

Student Lives With: Parents/Mother/Father/Guardian (please circle and provide full names) Dad Cell Phone _____

Name _____ Wk# _____ Name _____ Wk# _____

Please check below if your child has any of the following conditions:

Allergies: Food/Pollen requires treatment ___ Bee Sting Allergy requires treatment ___ Diabetes Type I ___ Type II ___ Migraines ___

Asthma requires treatment ___ Hearing Disorder requires modification ___ Heart Disorder restrictions ___ ADHD/ADD ___

Orthopedic Problem ___ Glasses ___ Always/Reading Major Surgery _____ Seizure Disorder _____

Explanation for any of the above or other conditions _____

Student's Physician _____ Phone _____ Dentist _____ Phone _____

Does your child use any medication? Yes/No If yes, please specify:

If a parent/guardian cannot be reached, and your child has an illness/emergency, whom may we call? (may list other names on back)

1. _____ Phone _____ Relationship _____

2. _____ Phone _____ Relationship _____

_____ Please check if you do not want your child to receive a blood transfusion or receive blood products in an emergency.

- We authorize this confidential information to be shared with all necessary school personnel as needed.
- It is the parent's responsibility to notify the school if the student is placed on medication or if there is a change in the student's physical condition, which limits his/her ability to participate in the regular physical education program.
- If your child needs immediate medical attention, and neither parent nor designated persons can be reached, a district employee will be authorized to call 911 at no expense to the district.

I, the parent/guardian hereby give my permission to do so.

Parent/Guardian Signature _____ Date _____

(Required)