STUDENT HEALTH AND EMERGENCY INFORMATION- One per student

Patient Information

Student LAST Name:	Student FIRST Name:	Date of Birth:
Grade in the fall: ☐ Senior ☐ Junior ☐ Sophomore ☐ Freshman	Home #: ( )	Student Cell#: ( )
Home Address:	City:	Zip:

Mother's full name:	Mom's email:	Mom's cell #:	Mom's work#:
Father's full name:	Dad's email:	Dad's cell#:	Dad's work#:

Primary Physician:	Physician's Phone Number:

EMERGENCY CONTACTS- If parent is not available. Must be in Local - Please provide two contacts

Name:	Relationship	Home Phone	Cell Phone	Work Phone:

MEDICAL CONDITIONS: Check all that apply

		ALLERIGIES:	MEDICATIONS:	
☐ ADD/ADHD ☐ Eating Disorder ☐ Anxiety/Panic Attacks ☐ Asthma ☐ Asthma Exercise Induced ☐ Cardiac Condition ☐ Concussion: list date/s below ☐ Inflammatory Bowel Disease ☐ Diabetes- Insulin Injection ☐ Diabetes- Insulin Pump ☐ Diabetes- Oral Medication ☐ Diabetes- CGM ☐ Depression	☐ Headaches ☐ Hearing Loss ☐ Hyper/Hypo thyroid ☐ Irritable Bowel Syndrome ☐ Migraine ☐ Mobility Impairment ☐ Fainting ☐ Nose Bleeds ☐ Seizures ☐ Surgeries Other:	☐ Bee/Wasp sting ☐ Eggs ☐ Fruit ☐ Latex ☐ Dairy ☐ Peanut ☐ Shellfish ☐ Soy ☐ Tree Nut ☐ Other Allergies, include medications.	☐ Epipen/Auvi Q ☐ Benadryl ☐ Rescue Inhaler ☐ Other-please list	By signing this form I acknowledge that my child's doctor has given approval for the use of these OTC medications below. May Acetaminophen (Tylenol) be given to this student by the nurse? ☐ Yes ☐ No May Ibuprofen (Motrin, Advil) be given to this student by the nurse? ☐ Yes ☐ No

Health information may be shared with appropriate staff in order to promote the students health and safety and to best access their educational program. This is done in a confidential manner with those with a need to know.

Parent/Guardian Signature: (required) Date:

Revised 9/15_