Health Card

	nealth Card	Grade:
Homer	room Teacher:	
Student's Name:		ate of Birth/
e see		
Address:		Phone #:
Name of Parent or Guardian:		
		ne #:
e-mail:		
Mother's Employer:		ne #:
	Mobile #:	
	Modic II.	
or ambulance expense incurred in t	annot be reached, the parent or guardian is re he best interest of your child.	sponsible for any nospital, doctor
In case of an accident or illness and	l you cannot be reached, list a person who w	e may contact:
		Phone #:
	Medical History (Circle all that apply)	
Visual Difficulties	Measles	Heart Disease
Rheumatic Fever Asthma	Frequent Respiratory Infections Diabetes	Other:
Allergies Type:		
Seizures: Type:		
	or have any hearing problem? Yes	No
7	ading childhood diseases:	
YOUR CHILD HAS A MEDICAL HISTO ABOUT, PLEASE GIVE COMPLETE IN	ON IS FOR THE SCHOOL NURSE AND WILL BE DRY OF ANY DISEASE OR CHRONIC AILMENT NFORMATION. IF YOUR CHILD HAS TO TAKE TON FORM MUST BE ON FILE IN THE NURSES	THAT YOUR NURSE SHOULD KNOW E PRESCRIBED MEDICATION, A COM-
THE NURSE MAY ALSO GIVE ASPIRIT HOME ACCORDING TO THE MEDICAL	N, TYLENOL OR OTHER OVER THE COUNTER FION POLICY.	MEDICINE THAT IS BROUGHT FROM
Signature:	rent of guardian) Date: _	
(pai	rent of guardian)	
Complete below for all persons of	her than parents/guardians previously lis	ted, authorized to pick up student.
Name:		1
Relationship:		
Name:	Phone #'s:	
Relationship:		
Name:	Phone #'s:	
Relationship:		Ä.