Health Card

Grade: _____

Homeroom Teacher: _____

Student's Name: _____ Date of Birth ____/____/_____
Last First Middle

Address: _____ Home Phone #: _____

Name of Parent or Guardian: _____

Father's Employer: _____ Phone #: _____

e-mail: _____ Mobile #: _____

Mother's Employer: _____ Phone #: _____

e-mail: _____ Mobile #: _____

Name of Family Physician: _____ Phone #: _____

In case of an emergency and you cannot be reached, the parent or guardian is responsible for any hospital, doctor or ambulance expense incurred in the best interest of your child.

In case of an accident or illness and you cannot be reached, list a person who we may contact:

_____ Phone #:_____

Medical History (Circle all that apply)

Visual Difficulties	Measles	Heart Disease
Rheumatic Fever	Frequent Respiratory Infections	Other:_____
Asthma	Diabetes	_____

Allergies: _____ Type: _____

Seizures: _____ Type:_____

Does your child wear a hearing aid or have any hearing problem? ____ Yes ____ No

Other illness or abnormalities, including childhood diseases:_____

_____

_____

_____

NOTE TO PARENT: THIS INFORMATION IS FOR THE SCHOOL NURSE AND WILL BE KEPT IN STRICTEST CONFIDENCE. IF YOUR CHILD HAS A MEDICAL HISTORY OF ANY DISEASE OR CHRONIC AILMENT THAT YOUR NURSE SHOULD KNOW ABOUT, PLEASE GIVE COMPLETE INFORMATION. IF YOUR CHILD HAS TO TAKE PRESCRIBED MEDICATION, A COMPLETED MEDICATION ADMINISTRATION FORM MUST BE ON FILE IN THE NURSES OFFICE.

THE NURSE MAY ALSO GIVE ASPIRIN, TYLENOL OR OTHER OVER THE COUNTER MEDICINE THAT IS BROUGHT FROM HOME ACCORDING TO THE MEDICATION POLICY.

Signature: _____ Date: _____
(parent of guardian)

Complete below for all persons other than parents/guardians previously listed, authorized to pick up student.

Name: _____ Phone #'s: _____

Relationship: _____ _____

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