Health Services **Health Information**

Name: _____ DOB: _____Date:_____
Campus: _____Grade: _____

Parent/guardian: _____ Home #:_____
Cell #: _____ Work #:_____
E-mail:_____
Parent/guardian: _____ Home #:_____
Cell #: _____ Work #:_____
E-mail:_____

In case of an emergency and parents cannot be reached, who should be contacted?
Name: _____ Home #:_____
Cell #: _____ Work #: _____
Physician: _____ Phone #:_____
Preferred Hospital: _____ Phone #:_____
Insurance: None ____ Medicaid ___ Texcare ___ CHIP ____ Other _____

Allergic to (food, insects, meds, etc.):	Type of reaction (rash, difficulty breathing, etc.):
_____	_____
_____	_____
_____	_____

Current medical diagnoses or handicaps: _____
_____

Past injuries/illnesses/hospitalizations/surgeries: _____
_____
_____

Medications:	Strength:	Dose:	Time Given:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Is there anything else we need to know about your student? _____
_____

I give permission for the school nurse to communicate with the above named physician and release information to the appropriate school personnel regarding my child's medical condition. I understand a copy of this form will be sent with EMS in an emergency.

_____ _____
Parent Signature Date