SCHOOL/TEACHER/GRADE: ____ **BUS # ______ (AM) ______ (PM)**	

HEALTH SERVICES INFORMATION

_______________ SCHOOL YEAR

STUDENT'S NAME: ____________________________________ DOB: ____________________________

HOME ADDRESS: ____ CITY, ZIP: ______________________

HOME PHONE: ____

PLEASE LIST ANY MEDICAL INFORMATION THAT WOULD BE HELPFUL:

Allergies: ____

Physical Limitations: _____________________________

Medications: ____

Diseases/Conditions: ______________________________

Other: ____

FAMILY DOCTOR: __________________________________ **PHONE:** ______________________________________

SPECIALIST: ______________________________________ **PHONE:** ______________________________________

If it is necessary for a student to take medication during school hours, the medication must be brought to the health room in the original container with a medication permission note signed by the parent/guardian and physician (for prescription medication). If your student has any health needs that will require emergency procedures, please contact the school nurse. **The above information will be available to your student's teacher, the health room assistant, and the school nurse**.

In the event of a serious accident or illness, I request the school to contact me. If I cannot be reached, the school shall make whatever arrangements are necessary to provide emergency care and treatment for my child. This may include conveyance to treatment at a hospital or other medical facility. I will assume responsibility of payment for services rendered. In the case of an accident or illness where immediate treatment is not indicated, but where he or she is unable to remain at school, I request that the school contact the emergency contacts that I have provided to the school.

Date: _________________ Signature: ____