SCHOOL HEALTH INFORMATION

This information is essential for prompt and efficient care of each student

Student's name_____________________________________DOB__________Grade________
Last First MI

Address____

School____________________________________Teacher___________________________

Mother/Guardian Name____________________Father/Guardian Name__________________

Primary Custodial Parent – Mother______Father______ N/A_____

Mother/Guardian Home #________________Work #______________Cell #______________

Father/Guardian Home #________________ Work #______________Cell #______________

1. List any medical conditions that are presently being monitored by a physician_______________
____

2. List allergies (food, medication or seasonal) and type of reaction experienced______________
____

NOTE: An additional form signed by a physician is required for food allergies, please see cafeteria manager for this

3. List current medications taken at home or school with the dosage and time_________________
____
____

Please note that medication to be given at school requires a form signed by the parent/guardian and/or physician and must be brought to school by the parent/guardian in proper container. See student agenda for more details

4. List surgeries and hospitalizations including dates____________________________________
____

5. List doctor's name and phone number, and hospital preference in case of emergency

___________________________________ ________________ ____________________
Doctor's name Phone Number Preferred Hospital

6. Does student have health insurance? _____Yes _____No
If yes, Health Insurance Name__________________________ID#__________Group#________

7. The following persons may be contacted and my child may be released in their care if the parent/ Guardian is unable to be contacted.

Name__________________________________Daytime phone___________Cell____________

Name__________________________________Daytime Phone___________Cell____________

Name__________________________________Daytime Phone___________Cell____________

Name__________________________________Daytime Phone___________Cell____________

Parent/Guardian Signature_________________________________Date___________________

Parent's signature gives Wilson County Schools permission to disclose and receive medical information on this student

THIS FORM MUST BE SIGNED AND TURNED IN TO YOUR SCHOOL NURSE