School Health Information Card

School Year: _____ *(PRINT & USE INK)* Grade: _____

Student: _____ ☐ M ☐F DOB: ____ /____ /_____
Last Name First Name Gender mm/dd/yyyy

With whom does student live? ☐ Both Parents ☐ Mother ☐ Father ☐ Guardian

		Mother	Father	Guardian
Parent/Guardian Information	**Name**			
	Address			
	Home Phone	( ) -	( ) -	( ) -
	Cell Phone	( ) -	( ) -	( ) -
	Work Phone	( ) -	( ) -	( ) -

In case of an emergency who is the primary contact? ☐ Mother ☐ Father ☐ Other_____

Emergency Contacts	**Please list three other people, who have your permission, to pick up your child in a timely manner from school and make decisions concerning your child in the event that you cannot be reached:**			
	Name/ Relationship			
	Home Phone	( ) -	( ) -	( ) -
	Cell/Work Phone	( ) -	( ) -	( ) -

Siblings In Other Schools	**Please list siblings that attend other schools in Dorchester School District Two.**			
	Name		**School**	
	Name		**School**	
	Name		**School**	

Healthcare Provider: _____ **Phone Number:** _____

I hereby authorize the principal or designee, into whose care the student has been entrusted, permission to exchange information with my child's healthcare provider. All information will be kept strictly confidential and used only to provide appropriate individualized healthcare services for my child while in school or school related event. In case of serious illness/injury, the school will telephone Emergency Medical Services (911) for immediate transportation to the closest hospital. I, the parent/guardian, authorize the transport of and treatment by the hospital and emergency staff for my child, _____
Print Student Name

Parent/Guardian Signature: _____ **Date**: _____

Health History

Allergies (Specify):			Epipen ☐ Y ☐ N
ADD/ADHD ☐ Y ☐ N	Cancer ☐ Y ☐ N	Cardiac Concern ☐ Y ☐ N	Seizure Disorder ☐ Y ☐ N
Asthma ☐ Y ☐ N	Diabetes ☐ Y ☐ N	Physical Handicaps ☐ Y ☐ N	Sickle Cell Disease ☐ Y ☐ N
Other: _____			

Does your child…

Wear Glasses? ☐ Y ☐ N Contacts? ☐ Y ☐ N Hearing Aid(s)? ☐ Y ☐ N

Take any prescribed medications routinely? ☐ Y ☐ N List_____

_____

To assure prompt attention to your child, PLEASE NOTIFY THE SCHOOL OF ANY CHANGE IN PHONE NUMBER, ADDRESS, OR HEALTH CONCERNS

HEALTH ROOM RECORD AND PROGRESS NOTES

Date	Time In	Description of Illness/Injury	Treatment	Time Out

Signature	Initials	Signature	Initials