Student Health & Information Record

Name of Child (Last, First, Middle Initial)		Child's Date of Birth
Address, City, State, Zip		Home Phone
Father/Legal Guardian's Name	Work Phone Cell Phone	Email Address
Mother/Legal Guardian's Name	Work Phone Cell Phone	Email Address

Health Information

Does this student have specific medical needs of which we should be aware (eyeglasses, allergies, etc.)? If yes, please

Describe:

Does this student require medication during regular school hours? Yes No (*circle*)

If yes, medication name and dosage:

Name of Child's Physician or Health Clinic	Hospital Preferred for Emergency Treatment
Name of Local Person to be Notified in an Emergency When Parents Not Available	Local Address of Emergency Contact
Home phone of Emergency Contact ( )	Cell Phone/Work phone of Emergency Contact ( )

As a parent/guardian, I do hereby authorize first aid/medical treatment of my child in the event of an emergency which may endanger his/her life, cause disfigurement, physical impairment, or undue discomfort if delayed. It is understood that efforts will be made to reach me as soon as reasonably possible.

Signature of Parent or Guardian	Date Signed

Release Authorization

Name(s) of person(s) other than Parent or Legal Guardian to whom your child may be released: