Health Information

Student Name: _____ Date of Birth: _____

Allergies: _____

In case of allergic reaction: _____

Name of Child's Doctor: _____ Phone #: _____

Previous operations / hospitalizations:

_____

Please note any medical conditions that we should be aware of (i.e. asthma, diabetes, etc.):

_____

Is your child currently taking any medication on a regular basis? _____

Would this medication be administered at school? _____
(If so, please complete a Medication Consent Form Available online)

Physical Limitations: _____

Is your child currently receiving special professional services? (i.e. speech therapy, physical therapy):

_____

_____ _____
Parent's Signature Parent's Cell Phone

_____ _____
Home Phone Parent's Cell Phone

_____ _____
Date Other Contact Number