



2740 N. Harbor City Blvd Melbourne, FL 32904 • 321-622-6884

Health Card

Name _____ DOB _____ Grade _____ Sex _____
Last First MI

Address _____ Home Phone _____
Street City Zip

Father _____ Employer _____ (W)Phone _____ (C)Phone _____

Mother _____ Employer _____ (W)Phone _____ (C)Phone _____

Daily Medication

Home

- 1. _____
- 2. _____

School

- 1. _____
- 2. _____

Diabetes:

(Circle Below) Type I Type II

Equipment/Intervention:

(Circle Below) Insulin Pen Insulin Pump Diet Management

Emergency Medication:

Glucagon:

Home | School | Both

Other Emergency Medication:

Allergies:

(Circle Below)

Insect Bites Foods Medicine Other Specific Allergies:

Emergency Medication:

Epinephrine (EpiPen):

Home | School | Both

Special Equipment:

(Circle Below)

Glasses/Contacts Wheelchair Gastric Tube Shunt
Hearing Aid Arm/Leg Braces Tracheostomy Catheter

Student's Physician Name: _____

Phone: _____

Parent/Guardian Name (Please Print): _____

Parent/Guardian Signature: _____

Date: _____