HEALTH OFFICE RECORD

STUDENT'S NAME _____ DATE OF BIRTH _____

FATHER'S NAME _____ MOTHER'S NAME _____

STUDENT'S ADDRESS _____ PHONE _____

_____ CELL _____

STUDENT LIVES WITH: BOTH PARENTS _____ OR FATHER _____ OR MOTHER _____

FATHER'S EMPLOYER _____ PHONE _____

MOTHER'S EMPLOYER _____ PHONE _____

EMERGENCY CONTACTS IN CASE NEITHER PARENT CAN BE REACHED:

NAME _____ PHONE _____

NAME _____ PHONE _____

PLEASE LIST ANY MEDICAL CONDITIONS THAT YOUR CHILD MAY HAVE: (EX. ASTHMA, DIABETES). IF NONE PLEASE CHECK HERE: _____

ALLERGIES: _____

IF NO ALLERGIES KNOWN PLEASE CHECK HERE: _____

PLEASE LIST ANY MEDICATIONS YOUR CHILD TAKES AND WHEN HE/SHE TAKES THEM:

_____

STUDENT'S PHYSICIAN _____

PLEASE LIST THE NAME OF THE PHYSICIAN AND HOSPITAL THAT YOU WOULD LIKE USED IN

CASE OF AN EMERGENCY _____

PARENT'S SIGNATURE_____ DATE _____