Health Information Form

Student's Name: _____ Sex: M F
Last First Middle

Address: _____
Street City State Zip

Phone: _____ Birth date: _____

Name of Parents or Guardian:
_____

Student's Physician: _____ Phone: _____

If the student has had any of the diseases or conditions listed below, indicate by giving the Age at the time of the disease or when the condition began.

Whooping Cough ____
Asthma ____
Frequent Colds ____
Heart Disease ____
Chicken Pox ____
Surgery _____
Ear Infections ____
Allergies ____
Pneumonia ___
Diabetes ____

Please list below any other serious disease, illness or surgery that the student has had, noting the dates and any other pertinent details. List any medication that the student takes on a regular basis.

_____

_____

_____

_____

_____

Please explain any physical or emotional condition which might require understanding to help your child to adjust well in school:

_____

_____

_____