

STUDENT HEALTH HISTORY

STUDENT'S FULL
NAME _____

(circle or specify name to be called)

(First)

(Middle)

(Last)

DATE OF BIRTH _____ MALE _____ FEMALE _____ SOC. SEC. # _____

INSTRUMENT _____ PRESENT GRADE _____
(required)

SCHOOL _____

HOME ADDRESS _____

PARENT OR LEGAL GUARDIAN _____

(circle ONE of the above)

(First)

(M.I.)

(Last)

OCCUPATION _____

HOME PHONE # _____ EMERGENCY# _____ CELL# _____

*HEALTH PROBLEMS _____

*DRUG, FOOD, OR OTHER ALLERGIES _____

*MEDICATIONS YOU TAKE

PURPOSE _____

FAMILY PHYSICIAN _____ PHONE # _____

INSURANCE COMPANY NAME & GROUP # _____

I GIVE PERMISSION TO ADMINISTER TYLENOL TO MY CHILD. YES _____ NO _____

PERMISSION IS GIVEN FOR TREATMENT OF MY STUDENT BY A PHYSICIAN AND/OR AT A
HOSPITAL FOR ANY MEDICAL OR SURGICAL EMERGENCY. YES _____ NO _____

PARENT OR LEGAL GUARDIAN _____

NOTARY

WITNESS _____

SEAL

NOTARY PUBLIC _____

Email address _____

