



CONFIDENTIAL
HEALTH HISTORY & PERMIT FORM

Name: _____ SS# _____ (optional) Grade: _____ Student ID _____
Address: _____ City/State/Zip _____
Date of Birth: _____ Age: _____ Sex M F Home Phone _____
Parent/Guardian Name: _____ Home Phone: _____
Work Phone: _____ Cell Phone: _____ Pager: _____
Student lives with: _____ Both Parents _____ Mother _____ Father _____ Other
Siblings: Name/Age 1 _____ 2 _____ 3 _____
4 _____ 5 _____ 6 _____

In case of Emergency and Parent/Guardian cannot be reached, contact:

1. Name _____ Day Phone _____
2. Name _____ Day Phone _____

HEALTH CONDITIONS: (Check all that apply)

- | | | |
|---|---|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Head Injury |
| <input type="checkbox"/> Surgery | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Special Dietary Needs |
| <input type="checkbox"/> ADD | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hearing Impaired |
| <input type="checkbox"/> Chronic Sore Throat | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Emotional Disturbances |
| <input type="checkbox"/> Chronic Menstrual Cramps | <input type="checkbox"/> Headaches | <input type="checkbox"/> Bone Disease |
| <input type="checkbox"/> Contact Lenses | <input type="checkbox"/> Chronic Stomach Ache | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Glasses | | <input type="checkbox"/> Other |

Please explain any answer that you checked above. Indicate any information useful to the nurse in relation to any of these health conditions:

MEDICATIONS: Please list any medication your child takes on a routine basis.

ALLERGIES: Describe which foods, medication, etc that causes allergies and the symptoms exhibited.

RESTRICTIONS: Is your child restricted from participating in any school physical education activity? Please explain.

School Attended last year: _____
Are there any other factors that the school nurse should know of which might affect your child's school experience?

I know of no health reasons, other than the information indicated on this form, which would restrict my child from participation in any school activity. I authorize school personnel to obtain emergency medical care for my child in the event I cannot be reached. If transportation by ambulance is required, this may be obtained.

Physician: _____ Phone # _____
Dentist: _____ Phone# _____
Preferred Hospital: _____
Medical Insurance Provider: _____ ID# _____
MC+/Medicaid Provider: _____
MC+/Medicaid Yes _____ NO _____ ID# _____

Date: _____ Parent/Guardian: _____
Signature