

HEALTH INFORMATION

Name of Physician/Clinic: _____ Telephone _____

Health Alert

Does child have any health condition that may affect participation in physical activities? Yes No

Limitations _____ (e.g., stair climbing, participation in gym)

Allergies _____

504 services for the current year? Yes No Previous Years? Yes No

My child has (X any that apply): Private health insurance Medicaid No health insurance

If "No Health Insurance," are you willing to share contact information from this card to learn about insurance options? Yes No

If none of the named contacts can be reached, what do you wish the school to do if your child is sick or injured?

It is understood that in the final disposition of an emergency case, the judgment of the school authorities will prevail.
The recommendation of the parent as indicated above will be respected as far as possible.

SIBLINGS

Sibling's Last Name	Sibling's First Name	Sibling's School of Attendance
_____	_____	_____
_____	_____	_____
_____	_____	_____

SIGNATURE OF PARENT/GUARDIAN

Principal will be notified in writing of any changes to information on this card _____
Signature of Parent/Guardian

FOR SCHOOL USE ONLY

To be completed by school staff only.

Grade _____ Class _____ Room No. _____ Teacher _____

List below contacts made for emergency, illness or injury. Relevant records from Health Record _____

Date	Contact	Reason	Disposition
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____