COLEGIO INTERNACIONAL PUERTO LA CRUZ

HEALTH FORM

Student's Last Name **First Name** **Middle Name**

_____ _____ _____

Date of birth:_____ **(circle)** Male Female
(Please write out the month, i.e. January 1, 1998)

Parent/guardian's Name:_____

Home Phone (Local):_____Work Phone:_____

Cellular Phone(s): _____ Email: _____

Other person if parent/guardian is not available in case of emergency:

_____

Telephone number of the person above:_____

Hospital of choice for emergency purposes:_____

Please indicate if your child has any medical conditions and/or allergies:

Please sign below to give the school nurse permission to administer general first aid or give over the counter medications such as:

- Appropriate strength Tylenol or Ibuprofen
- Benadryl
- Ear Drops
- Eye Drops
- Throat lozenges/antiseptic
- Antibiotic cream

NOTE: Immunization Records are mandatory for medical file.

_____
Parent Signature