



Student 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: \_\_\_\_\_

Mother's Cellular Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Father's Cellular Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Other authorized, adult emergency contact in case a parent/guardian is not available:

\_\_\_\_\_

Telephone number of the emergency contact above: \_\_\_\_\_

Please indicate if your child has any medical conditions and/or allergies (medicine, food / others): \_\_\_\_\_

\_\_\_\_\_

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Sign below to authorize the school doctor to administer general first aid and/or give over the counter medications such as:

- Appropriate strength Tylenol, Ibuprofen, or Diclofenac (in case of fever or pain)
- Antihistamines (In case of allergic reaction)
- Gastrointestinal medication (in case of nausea, indigestion, diarrhea, or heartburn)
- Ear Drops
- Eye Drops
- Throat lozenges/antiseptic
- Pain relief or Antibiotic cream (for scrapes, bruises, etc)

**NOTE: Current, updated immunization records are mandatory for your child's medical file. Please send a copy of their current immunization records to the school doctor.**

\_\_\_\_\_ Parent Signature

\_\_\_\_\_ Date