STUDENT HEALTH UPDATE

VERY IMPORTANT! This form must be completed and kept on file in the nurse's office. Please print!

Name________________________Birth date____________Student Number__________

Address____

Name of Apartment Complex______________________________Apartment Number________

City________________________________Zip__________Home Phone__________

Father or Guardian's Name____

Relationship to Student (if not father)__________________________Work Phone__________

Mother or Guardian's Name______________________________Work Phone__________

Relationship to Student (if not mother)____________________Work Phone______________

Emergency Contact (if we are unable to reach parent or guardian)

Name__________________________________Relationship to Student______________

Home Phone____________________________Work Phone_________________________

Name of Family Doctor__________________________Phone____________________

Hospital Preference____

Other Children Living at Home (include name, relationship to student, and birth date)

Boys____

____

Girls____

____

Please check this student's health problems:

☐ Allergies ☐ Asthma ☐ Diabetes ☐ Epilepsy ☐ Cardiac ☐ Hearing ☐ Vision

☐ Other____

Does this student wear glasses? ☐ Yes ☐ No **Contact Lenses?** ☐ Yes ☐ No

Write the name and purpose of medications currently being taken by this student. (Include prescription drugs, as well as over-the-counter drugs, vitamins, birth control, etc.)

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Previous School______________________________City______________State________

Parent or Guardian Signature____