

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.)

Previous School _____ City _____ State _____

Parent or Guardian Signature _____