

HEALTH FORM

STUDENT'S NAME _____

PHONE # _____ DATE OF BIRTH _____

If your child has special needs (Learning disabilities, handicaps, allergies, etc.) please indicate below:

If your child has a condition that could result in us having to administer a particular type of medication, please have available to us an instruction sheet, and a letter of permission signed by you.

EMERGENCY CONTACT PERSON: (only in the event a parent is not available)

NAME _____ PHONE # _____

HEALTH INSURANCE CO. _____ POLICY # _____

FAMILY PHYSICIAN _____ PHONE # _____

Please list below any additional information we should know.

ALL INFORMATION IS KEPT STRICTLY CONFIDENTIAL!!!