



CONFIDENTIAL

HEALTH HISTORY & PERMIT FORM

Name: _____ SS# _____ (optional) Grade: _____
 Address: _____ City/State/Zip _____
 Date of Birth: _____ Age: _____ Sex M F Home Phone: _____
 Parent/Guardian Name: _____ Home Phone: _____
 Work Phone: _____ Cell Phone: _____ Other Phone: _____
 Student lives with _____ Both Parents _____ Mother _____ Father _____ Other _____
 Siblings: Name/Age 1 _____ 2 _____ 3 _____
 4 _____ 5 _____ 6 _____

In case of Emergency and Parent/Guardian cannot be reached, contact:

1. Name _____ Day Phone _____
 2. Name _____ Day Phone _____

HEALTH CONDITIONS: (Check all that apply)

- | | | |
|---|---|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Head Injury |
| <input type="checkbox"/> Surgery | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Special Dietary Needs |
| <input type="checkbox"/> ADD | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hearing Impaired |
| <input type="checkbox"/> Chronic Sore Throat | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Emotional Disturbances |
| <input type="checkbox"/> Chronic Menstrual Cramps | <input type="checkbox"/> Headaches | <input type="checkbox"/> Bone Disease |
| <input type="checkbox"/> Contact Lenses | <input type="checkbox"/> Chronic Stomach Ache | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Glasses | | <input type="checkbox"/> Other |

Please explain any answer that you checked above in the space below. Use a separate sheet of paper, if necessary.
 Indicate any useful information in relation to any of these health conditions. _____

MEDICATIONS: Please list any medication your child takes on a routine basis. Use a separate sheet of paper if necessary.

ALLERGIES: Describe which foods, medication, etc. that causes allergies and the symptoms exhibited. _____

RESTRICTIONS: Is your child restricted from participating in any school physical education activity? Please explain. _____

School Attended last year: _____ Are there any other medical/health factors of which we should know, that might affect your child's school experience? _____

Physician: _____ Phone: _____
 Preferred Hospital: _____
 Medical Insurance Provider: _____ ID# _____
 MC+/Medicaid Provider: _____
 MC+/Medicaid Yes _____ No _____ ID# _____

I know of no health reasons, other than the information indicated on this form, which would restrict my child from participation in any school activity. I authorize school personnel to obtain emergency medical care for my child in the event I cannot be reached. If transportation by ambulance is required, this may be obtained.

Date: _____ Parent/Guardian Signature: _____