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 Name of Apartment Complex Apartment Number City_____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)** _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) Please check this student's health problems: ☐ Ásthma ☐ Diabetes ☐ Epilepsy ☐ Cardiac ☐ Hearing ☐ Vision Allergies 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____