South Harrison Community School Corporation
Student Health Information Sheet--Confidential--Kept in Nurse's Office

Student Name _____ M/F_____ Date of Birth _____ Grade_____
Parent(s)/Guardian(s) _____
Home Address _____ City _____ Zip _____
Phone # Home _____ Work _____ Cell _____
Emergency Contact Name _____Phone # _____ Relationship _____
E-mail address _____

Siblings: Please list all names (first and last) and ages
Name _____ Age _____ Name _____ Age _____
Name _____ Age _____ Name _____ Age _____
Name _____ Age _____ Name _____ Age _____

In case of a medical emergency, list numbers in order you want contacted:
#1 Name _____ Phone # _____
#2 Name _____ Phone # _____
#3 Name _____ Phone # _____

Family Doctor _____ **Phone #** _____

Medical Conditions-This information may be shared with staff in direct care of your child during the school day, school events (sports, dances, etc.) and/or accompanying child on field trips.

Asthma	Y	N	Chicken Pox	Y	N (Month _____/Year _____)
Diabetes	Y	N	Whooping Cough	Y	N
Mumps	Y	N	Vision Problems	Y	N
Measles	Y	N	Heart Condition	Y	N
Seizures	Y	N	Speech Problems	Y	N
Allergies	Y	N (If Y, then please list allergies and reactions below*)			

***Allergies (latex, bee stings, medications, foods)? What type of reaction occurs**?
_____
***Does your child have a Life Threatening Allergy requiring an Epi-Pen?** _____
_____

History of Illness, Surgeries, Medical Conditions, &/or Diseases:
_____

Medications: Please list all medications your child is taking (home or school), dose, and frequency
_____
_____

_____ I give the school nurse permission to contact my child's physician to discuss information related to medications and medical concerns regarding my child.

_____ I do not wish to give the school nurse permission at this time to contact my child's physician regarding my child's medical concerns.

_____ _____
Parent/Guardian Signature Date

Revised 2/2/17