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_____