2025-26
HEALTH INFORMATION

STUDENT NAME _____

PARENT'S NAME _____

ADDRESS _____

PHONE NUMBERS - HOME _____ WORK _____ CELL _____

SPECIFIC HEALTH CONDITION, IF ANY _____

_____

_____

MEDICATION, IF NEEDED _____

_____

PHYSICIAN'S NAME _____

ADDRESS _____

PHONE NUMBER _____

WHO TO CALL IN AN EMERGENCY, IF UNABLE TO CONTACT PARENT:

_____

PHONE NUMBER _____

NOTE: The school district will not be providing over the counter medications, such as Advil, Aleve, Tylenol and antacids, to students. They will have to provide their own.

I give my son/daughter permission to keep the following over the counter medications in their locker:

Advil, Aleve, Tylenol and Antacids

PARENT'S SIGNATURE _____ Date _____