

Student Health Information Form

School: _____ Date: _____

Name of Student: _____ Date of Birth: _____

Parent/Guardian: _____ Signature: _____

Home Telephone #: _____ Work #: _____

Physician: _____ Telephone: _____

To be completed by parent:

Child's Name: _____ Grade: _____ Teacher: _____

Medical Condition: _____

Symptoms:

Plan of Action: (Number in order of priority 1 being most important)

Administer Medication ___ Call 911 ___ Call Parents ___

Provide snack (if appropriate) ___ Other ___

Comments: _____

Thank you,

Carrie Meinert