2018-19 HEALTH FORM – **(copy of insurance card is required)**
(Please print)

Child's Name_____Grade_____

Address _____

City/State/Zip _____

Home Phone (_____) _____

Cell Phone (Mother) (_____) _____

Work Phone (Mother) (_____) _____

Cell Phone (Father) (_____) _____

Work Phone (Father) (_____) _____

Other Emergency Contact Name _____

Relationship to child_____

Phone Number (_____) _____

Other Emergency Contact Name _____

Relationship to child_____

Phone Number (_____) _____

Health Insurance Company _____
(Please attach a copy of health insurance card)

Employer Providing _____

Hospital Preference _____

Family Doctor and Phone Number _____

Does your child have any allergies? _____yes _____no

Please indicate:_____

Does your child take any prescription medication? _____yes _____no

Please explain:_____

Is there any special information about your child the school may need to know?

_____

I agree that school personnel may authorize emergency medical treatment for the above named youth.

_____ _____
Parent Signature Date