**(SCHOOL NAME)**

**Student Health Information Form**

**Student:**

Legal Name: Last \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Name (Nickname):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: ☐Female ☐Male ☐Non-Binary

Pronouns: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade: \_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Home Address: City, State, Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Parent/Guardian Emergency Contacts:**

Primary Contact Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Student:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alternate Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary Contact Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Student:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alternate Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Additional Emergency Contacts:**

Alternative Contact Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_

Alternative Contact Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_ \_\_\_\_\_

**Does the student have a current education plan:** ☐ IEP or ☐ 504

**Please check health problems the student has now, OR has had in the past:**

* Birth weight less than 5 lbs. ☐Developmental Delay ☐Allergies (list below) ☐Significant Injury
* Disabilities/Limitations ☐Ear Infections/Earaches ☐Hearing Loss ☐Sleeping
* Concussion/Head Injury ☐Significant Skin Problem ☐Vision ☐Glasses
* Stomach Problem/Ulcer ☐Heart Condition ☐Bone/Joint Disease ☐Asthma
* Eating/Weight ☐Blood Disease ☐Frequent Bronchitis ☐Seizures
* Frequent Strep Throat ☐Diabetes/Hypoglycemia ☐Operations ☐Headaches
* Nervous/Attention Disorder ☐Pneumonia ☐Emotional ☐Other

**If you have checked any of the above, please explain:**

Is the student covered by any health insurance? ☐Private ☐CHP+ ☐Medicaid ☐HIS ☐None

Is the student covered on any vision insurance? ☐No ☐Yes

Is the student currently under medical care? ☐No ☐Yes

**If yes, please describe:**

Does your child take medication? ☐No ☐ Yes **If yes, please provide the following:**

Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dosage: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time(s) Given: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_At School? ☐No ☐Yes

\*\*Emergency Medications Taken: ☐Epi-Pen ☐Inhale ☐Other \_\_\_\_

(For all emergency and at school administered medications, a medication authorization for OTC and Rx Form is required)

Doctor’s Name Dentist’s Name \_\_

Doctor’s Phone Optometrist’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, the undersigned, do hereby authorize school officials to contact directly the persons named on this form, and do authorize the named physicians/dentist such treatment as may be deemed necessary in an emergency, for the health of said child. In the event physicians, other persons named on this form, or parents cannot be contacted, the school officials are hereby authorized to take whatever action is deemed necessary in their judgment, for the health of said child. I will not hold the school district financially responsible for the emergency care and/or transportation for said child. I also understand that my child’s immunization records could be entered into the Colorado Immunization Information System.

Parent Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_