

Student's Medical History

Emergency Contact Information:

Child's Name: _____	Home phone: _____	Parent's Cell Phone &/or Pager: _____
Mother's Name: _____	Work Phone: _____	
Father's Name: _____	Work Phone: _____	Phone: _____
Emergency Contact Person (other than parents): _____		

Health Insurance

Carrier name: _____
 Policy number: _____

Doctor(s) Name	Phone Number	Address
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Current Medications	Medication Allergies
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Food Allergies	Other Allergies
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Previous/Current Illnesses, Injuries, and/or Surgeries	Date
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Please list any special needs, restrictions, and/or any other health concerns below:

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Immunizations	Date of Basic Immunization	Date of Last Booster
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Polio		
DTP		
Hib		
Hepatitis B		
MMR		
Varicella Virus (Chicken Pox)		