HEALTH INFORMATION SHEET

Student Name:_____ **Birth Date:** _____ **Grade:**____
Last First MI

Address: _____ Home Telephone: _____

City: _____ Zip Code: _____

TO PARENT OR GUARDIAN: To serve your child in case of **ACCIDENT OR SUDDEN ILLNESS,** it is necessary that you furnish the following information. This information will be shared with appropriate school personnel.

EMERGENCY CALLS

	Name	Cell Phone	Work Phone
Mother:	_____	_____	
Father:	_____	_____	

If not available, whom else may we call for help?

1. _____ _____
2. _____ _____
3. _____ _____

Please **check** health problems your child has **now or has had in the past:**

____Birth weight less than 5 lbs.	____Developmental Delays	____Allergies	____Other
____Disabilities/Limitations	____Ear Infections/Earaches	____Hearing Loss	
____Concussion/Head Injury	____Headaches	____Vision Problems	
____Stomach Problem/Ulcer	____Significant Injury	____Bone/Joint Disease	
____Asthma	____Eating/Weight Problem	____Blood Disease	
____Frequent Bronchitis or Pneumonia	____Frequent Strep Throat	____Seizures	
	____Nervous/Attention Disorder	____Heart Condition	
____Diabetes/Hypoglycemia	____Significant Skin Problem	____Operations	
____Emotional Problem	____Sleeping Problem	____Glasses	

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

_____

Do you have health insurance for your child? ☐**Yes** ☐**No**

Please read and sign:

As a parent/guardian of the child named above, I give permission to disclose information from my child's educational records to local, state, and federal agency representative(s) for the sole purpose of claiming Medicaid reimbursements for health-related support services, if eligible. I further understand that my child is entitled to free appropriate public education and that he/she will continue to receive services at no cost to me.

_____ _____
Parent/Guardian Signature Date

Is your child currently under medical care? ☐Yes ☐No

If **Yes**, please describe condition: _____

Does your child take medication? ☐Yes ☐No

If **Yes**, Type: _____ Dosage: _____Time given: _____

Immunizations received in the past year: _____ Date: _____

Date of last medical exam: _____ Doctor's Name: _____

Date of last vision exam: _____ Doctor's Name: _____

Date of last dental exam: _____ Dentist's Name: _____

I, the undersigned, do hereby authorize officials of Durango School District 9-R 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 judgement, 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.

_____ _____
Parent Signature Date