Student's Medical History

Emergency Contact Information

Child's Name:_____________________ Home Phone:___________________

Mother's Name:___________________ Mother's Cell:___________________

Father's Name:____________________ Father's Cell:____________________

Emergency Contact Person (other than parents):_____________________ Phone:____________

Health Insurance

Carrier Name:____

Policy Number:____

Doctor(s) Name	Phone Number	Address

Current Medications	Medication Allergies

Food Allergies	Other Allergies

Previous/Current Illnesses, Injuries and/or Surgeries	Date

Please list any special needs, restrictions and/or any other health concerns below:

****IMMUNIZATION DATES REQUIRED****

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

EXACT IMMUNIZATION DATES ARE REQUIRED EVERY YEAR