LS Health Form

Teacher_____

Grade_____

Student's Name _____ Birthdate _____

Race/Ethnicity: _____ American Indian/Alaskan Native _____ Native Hawaiian/Pacific Islander _____ Asian

_____ Black/African American _____ Hispanic/Latino _____ White _____ Other

Parents _____ Home Phone _____

Address_____

Father's Employer_____ Phone _____ Cell Phone _____

Mother's Employer_____ Phone _____ Cell Phone _____

Family Doctor_____ Phone _____

Do you grant permission to school personnel to contact a local doctor in the event your family doctor named above is not available? Yes No

Do you grant permission to school personnel to take your child to any hospital? Yes No

If your answer to either of the two previous is "no", please give alternate instructions: _____

Name of preferred hospital _____ Phone _____

Persons to contact in case of emergency if parents cannot be reached:

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Does your child have any of the following health problems? (Please circle) Fainting spells Epilepsy Diabetes

Allergies (please list) _____

Please note any information the school should have regarding your child's health.

_____

Please list any medications your child is taking _____

_____

Only medication provided by the parent or guardian will be administered to Lower School students.

No medication, prescription or nonprescription, will be administered to a student without a parent's written authorization.

Medication Authorization Forms are available in the main office, LS Guidance Office, or from your child's teacher.

Parent's signature_____Date_____

*List person(s) your child may be released to:

Name	Relationship to the child	Address	Telephone Number