Activity: _____ School Year: _____

MOUNTAIN BROOK CITY SCHOOLS
STUDENT HEALTH INFORMATION

School: _____ **Grade/Homeroom:** _____

Student Name: _____ **Date of Birth:** _____
Last First Middle

Student Cell Phone: **Parent Preferred Email:**

Emergency Contact Information: *Please list in order to be contacted, please include yourself:*

1. Name: _____ **Relationship to Student** _____
Home Phone: *Work Phone:* *Cell Phone:*

2. Name: _____ **Relationship to Student** _____
Home Phone: *Work Phone:* *Cell Phone:*

3. Name: _____ **Relationship to Student** _____
Home Phone: *Work Phone:* *Cell Phone:*

Health Information

The information provided may be made available to school and emergency personnel as needed

Medical Conditions, Chronic Illness, Disabilities: _____

Allergies: Food: No ☐ Yes ☐ _____
Medications: No☐ Yes ☐_____
Other: No ☐ Yes ☐ _____

Check any current condition that may require attention during the school day.

Yes	No		Yes	No	
☐	☐	Allergies: Medications at school? ☐yes ☐no	☐	☐	Heart Problems (specify)
☐	☐	Asthma: Medication at school? ☐yes ☐no	☐	☐	Mental Health Condition
☐	☐	Attention Deficit: Medication at school ☐yes ☐no	☐	☐	Orthopedic/Muscular Problems
☐	☐	Bleeding Disorder	☐	☐	Respiratory Problems (specify)
☐	☐	Cancer	☐	☐	Seizures: medication at school? ☐yes ☐no
☐	☐	Diabetes	☐	☐	Stomach/ G.I. Problems (specify)
☐	☐	Headaches	☐	☐	Vision Problems (specify) ☐Corrective Lens
☐	☐	Hearing Problems, ☐Hearing Device	☐	☐	Other

Please describe conditions listed above: _____

Medical treatments needed at school: _____
(Please notify the school nurse of nursing care required during school hours.)

Medications: List all medications and dosages your child receives on a daily basis: _____

Physician Information

My child's medical care is provided by: _____ ( )
Name of Physician Telephone number

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Insurance Information

Student's Insurance: _____ Subscriber's Name: _____ Contract Number: _____

As a parent/guardian, I consent to have my child receive first aid by school staff and volunteers. If necessary, I consent to have my child transported to receive emergency care. I will be responsible for all charges not covered by insurance. I give consent for the emergency contact person listed above to act on my behalf until I am available. I agree to review and update this information whenever a change occurs and at least every school year.

Parent/Guardian Signature: **Date:**