HAZLEHURST CITY SCHOOL DISTRICT
Student Health Record

Student's Name:____ Date of Birth:_________________

Address:___________________________________ Home Ph:________________Cell Ph:_____________

School:________________________________ Grade:____ Homeroom:____ Male:__ Female:___ Age:___

Father/Mother/Guardian:______________________________________ Work Ph:___________________

Emergency Contact Person:________________________(relationship)___________ Phone:__________

Social Security No.:______________ Medicaid No.: _________________ Health Ins.:________________

Students Medical History

Problem	No	Yes	Past &/ or current problem (explanation of severity)
Allegries to drugs and food			
……insect bite or stings			
…..other			
Asthma			
Attention deficit/ADD/ADHD			
Birth defect/physical handicap			
Bone or joint problems			
Convulsions (seizure/epilepsy)			
Diabetes (high blood sugar)			
Emotional/Psychological disorder			
Headaches (frequent or on medication)			
Heart problem			
High blood pressure			
Nose bleeds			
Sinus problem			
Speech and/or Hearing problems			
Stomach or digestive problems			
Surgery			
Vision (seeing) problems			Glasses? ____yes ____no Contacts___ _yes ____ no

Describe any handicap or special needs of student: ____

____

Student's Doctor or primary Care Provider:________________________________ Phone No: _________

Is the student taking daily medication? No ___ Yes—Name:______________________________________

I give my permission for my child to participate in the schools health program and to receive first aid care and health education from the school nurse (or from school personnel as designated by the principal). This may include basic vision, hearing, and scoliosis screening, body and vital measurements, and school health education programs.

I give my consent for medical information to be shared between the medical provider and the school nurse and/or school personnel who would be directly involved in my child's medical care.

Parent/Guardian Signature:____ Date:________