



# The Emily O. Goodridge-Grey Accelerated Charter School

## Health Information Form 2007-08

Date: \_\_\_\_\_

Student Name: \_\_\_\_\_ Current Grade: \_\_\_\_\_

Birth date: \_\_\_\_\_ Male: \_\_\_\_\_ Female: \_\_\_\_\_

Does your student have any of the following conditions?

Please check off all that applies

Allergies to:

Medication \_\_\_\_\_ Latex \_\_\_\_\_

Foods (please list) \_\_\_\_\_

Bee Sting \_\_\_\_\_ Seasonal \_\_\_\_\_

Asthma \_\_\_\_\_ (Needs daily meds at school) Yes \_\_\_ No \_\_\_

Special Ed \_\_\_\_\_ (IEP) Yes \_\_\_ No \_\_\_

Hearing impairment \_\_\_\_\_

Diabetes \_\_\_\_\_

Headaches \_\_\_\_\_

Other health issues (Please list)

Is your student physical activity limited in any way? Yes \_\_\_ No \_\_\_

If yes, explain \_\_\_\_\_

Does your student take any medications? Yes \_\_\_ No \_\_\_

**(All medications at school must be administered within school procedure guidelines)**

Name of Medication(s) \_\_\_\_\_

Permission for school to give child over the counter pain medication \_\_\_ yes \_\_\_ No

Doctor or Clinic Name \_\_\_\_\_ Telephone \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Telephone \_\_\_\_\_ (Hm) \_\_\_\_\_ (Wk) \_\_\_\_\_ Cell \_\_\_\_\_

### In Case of Emergency

In case of an emergency, the school will not hesitate to seek proper medical care for the child. I understand that the school will attempt to contact me as soon as possible and that the school may transport my child to the nearest hospital or call an ambulance. I give the school my permission to provide and authorize emergency medical care if necessary.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

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