

**Madison County Schools  
Student Health Information**

Student: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Sex:  M  F School: \_\_\_\_\_ Grade: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Other Phone Numbers (cell, beeper, etc.) \_\_\_\_\_

Person to contact if parents are not available:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

<u>Do you have:</u>	Yes	No	
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Specify: _____
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Inhaler on person: <input type="checkbox"/> yes <input type="checkbox"/> no _____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Take insulin: <input type="checkbox"/> yes <input type="checkbox"/> no _____
Epilepsy or Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Specify: _____
Heart Conditions	<input type="checkbox"/>	<input type="checkbox"/>	Specify: _____

<u>Do you:</u>	Yes	No		Yes	No
Have medical insurance	<input type="checkbox"/>	<input type="checkbox"/>	Have severe nose bleeds:	<input type="checkbox"/>	<input type="checkbox"/>
Have trouble hearing:	<input type="checkbox"/>	<input type="checkbox"/>	Have vision problems:	<input type="checkbox"/>	<input type="checkbox"/>
Wear a hearing aid:	<input type="checkbox"/>	<input type="checkbox"/>	Wear glasses for:		
Need special seating:	<input type="checkbox"/>	<input type="checkbox"/>	distance <input type="checkbox"/> close work <input type="checkbox"/>		
Wear contact lenses:	<input type="checkbox"/>	<input type="checkbox"/>			
Have a condition which restricts regular participation in P.E.:					

Specify: \_\_\_\_\_

Comment: \_\_\_\_\_

- Medical History**
1. Currently have health problems:  Yes  No If yes, explain briefly: \_\_\_\_\_
2. Currently taking medication\*:  Yes  No Type: \_\_\_\_\_  
*\*A written request for medication administration during the school day is required. If you currently take, or will be taking medication at school, please request a medicine permission form to be signed by the parent/guardian and physician.*
3. I will take medication at school:  Yes  No

This information is confidential and will be shared with other medical personnel or school personnel only when deemed necessary.

Local Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Physician's Address: \_\_\_\_\_

Signature of Student: \_\_\_\_\_ Signature of Parent/Guardian: \_\_\_\_\_

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

*You will be requested to complete and update this Student Health Information annually.*