

HEALTH INFORMATION

Name of Physician/Clinic: _____ Telephone () _____

Health Alert

Does child have any health condition that may affect participation in physical activities? Yes _____ No _____
Limitations _____ (e.g., stair climbing, participation in gym)

Allergies _____
504 services for the current year? Yes _____ No _____ Previous Year? Yes _____ No _____

My child has (X any that apply): Private health insurance _____; Medicaid _____; No health insurance _____
If "No Health Insurance," are you willing to share contact information from this card to learn about insurance options? Yes _____ No _____

If none of the named contacts can be reached, what do you wish the school to do if your child is sick or injured?

It is understood that in the final disposition of an emergency case, the judgment of the school authorities will prevail.
The recommendation of the parent as indicated above will be respected as far as possible.

Siblings: Last Name	First Name	School of Attendance
_____	_____	_____
_____	_____	_____
_____	_____	_____

FOR SCHOOL USE

Date	Contact	Reason	Disposition
/ /	_____	_____	_____
/ /	_____	_____	_____
/ /	_____	_____	_____