Madison County Schools
Student Health Information

Student: _____ Date of Birth: _____
Last *First* *MI*
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: _____

Do you have:	**Yes**	**No**	
Allergies	☐	☐	Specify: _____
Asthma	☐	☐	Inhaler on person: ☐ yes ☐ no _____
Diabetes	☐	☐	Take insulin: ☐ yes ☐ no _____
Epilepsy or Seizures	☐	☐	Specify: _____
Heart Conditions	☐	☐	Specify: _____

Do you:	**Yes**	**No**		**Yes**	**No**
Have medical insurance	☐	☐	Have severe nose bleeds:	☐	☐
Have trouble hearing:	☐	☐	Have vision problems:	☐	☐
Wear a hearing aid:	☐	☐	Wear glasses for:		
Need special seating:	☐	☐	distance ☐ close work ☐		
Wear contact lenses:	☐	☐			

Have a condition which restricts regular participation in P.E.:

Specify: _____

Comment: _____

Medical History	**Yes**	**No**	
1. Currently have health problems:	☐	☐	If yes, explain briefly: _____
2. Currently taking medication*:	☐	☐	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: ☐ ☐

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

Local Physician' 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.