Carrollton-Farmers Branch Independent School District

Health Services Student Information Sheet

(To be completed by parent/guardian of student)

Student's Name_____ M / F Grade/Teacher_____
Last First Middle

Address_____ School ID _____

Phone _____ Birth Date _____

Mother's Name _____ Daytime Phone_____

Father's Name _____ Daytime Phone _____

In the event that a parent cannot be reached, the following people have permission to pick up this student from school if they are sick or injured: (**We cannot release your child to anyone who is not listed below.)**

Name_____ Daytime Phone _____

Name _____ Daytime Phone _____

Name _____ Daytime Phone _____

HEALTH HISTORY (Some conditions may require a statement from a physician for classroom modifications.)

Does the student…	Yes	No	Does the student…..	Yes	No
…have a vision problem?			…have bladder problems?		
…wear glasses?			…have bowel problems?		
…wear contacts?			…have heart problems?		
…have hearing problems?			…have seizures?		
…wear hearing aids?			…have diabetes?		
…have asthma?			…have any physical restrictions?		
…have allergies?			…take daily medication (list below)		
…have an allergy that would cause anaphylactic reaction?			Will the student need to take medication while at school?		
…ever require hospitalization due to asthma?			Has the student ever been hospitalized?		
…have depression, anxiety, or emotional concerns?			Has the student ever sustained a serious injury?		
…have ADD/ADHD?			Are there any other concerns?		

If the answer to any of the above is YES, please explain:_____

_____

If medication will be taken at school, please see your school nurse for the proper form.

Physician Name_____ **Phone**_____

Medications must be kept in the school clinic

NO NOTE – NO MEDICATION – NO EXCEPTION

In case of an emergency, I authorize the school to initiate emergency care.

Release:

I hereby grant permission for my child's physician to report his/her findings to authorized personnel of the C-FBISD.

I agree to notify the school of any changes to information listed above.

I hereby grant permission for information on my child's health problem(s) to be shared with authorized personnel of C-FBISD.

_____ Date_____

(Parent/guardian signature)

Revised 5/28/08