Student Health Record

Student's Name _____ School _____ Grade _____ Date _____

Birthdate _____ Parent/Guardian _____

Address _____

Home Phone # _____ Mother's Work # _____ Cell Phone # _____ Pager # _____

Father's Work # _____ Cell Phone # _____ Pager # _____

Emergency Contact (Is the person on the pick-up list?) _____

Home Phone # _____ Work Phone # _____ Cell Phone # _____ Pager # _____

List brothers/sisters attending Tift County Schools and what school each attends

_____ _____

_____ _____

Medical History (check all that apply*):

☐ Arthritis	☐ Convulsions w/fever	☐ Migraines
☐ Asthma	☐ Cystic Fibrosis	☐ Missing Organs (eye, kidney)
☐ Bleeding Problems	☐ Dental Problems	☐ Poor Weight Gain
☐ Blood Pressure	☐ Diabetes	☐ Premature Birth
☐ Bowel/Bladder Problem	☐ Fainting Spells/Dizziness	☐ Rheumatic Fever
☐ Breathing Problems	☐ Frequent Headaches	☐ Seizures
☐ Broken Bones	☐ Frequent Nose Bleeds	☐ Speech Difficulty
☐ Bronchitis	☐ Hearing Problems	☐ Surgery/Hospitalization
☐ Chronic/Recurrent Illness	☐ Heart Murmurs	☐ Vision Problems/Contacts
☐ Chest Pain	☐ Heat Exhaustion	☐ Other

*Please explain all checked answers on the back.

Does your child have any potentially life-threatening condition that is not listed above? ☐ Yes ☐ No If yes, please explain:

_____

_____

Describe how the above checked items affect your child at school.

_____

_____

Are there any known allergies, including medication, food, and/or environment?

_____

What kind of reaction occurs with these allergies?

_____

List *all* daily medication, including home and school.

_____

Current Physician: _____ Family Pediatrician: _____ Specialist: _____

After School Program: _____

After School Daycare (Name): _____

Car Ride: _____

Bus #: _____