



STUDENT INFO

First Name	MI	Last Name	Suffix
Birth Date (mm/dd/yyyy)		Primary Phone () -	<input type="checkbox"/> Mobile
Primary Email		<input type="checkbox"/> Personal email <input type="checkbox"/> Family email	
Student is allowed to walk, ride bus or bicycle home?			

HEALTH HISTORY

Operations/Past Medical Treatments	
Exempt Activities	
<input type="checkbox"/> Currently on Medication	Current Meds Name/Dose
Condition the medication is for?	

PARENT INFO

Legal Custody:		Legal Custody:	
Father/Guardian:		Mother/Guardian:	
Address:		Address:	
Home Phone:		Home Phone:	
Work Phone:		Work Phone:	
Cell Phone:		Cell Phone:	
Email:		Email:	
Drivers Lic:		Drivers Lic:	
Auto Insurance:		Auto Insurance:	

CONDITIONS REQUIRING CONSIDERATION

<input type="checkbox"/> Heart defect/disease	<input type="checkbox"/> Bleeding Disorders
<input type="checkbox"/> Recent Hospitalization	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Autism
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Asperger's Syndrome
<input type="checkbox"/> Asthma	<input type="checkbox"/> Hypertension
<input type="checkbox"/> Seizures/Convulsions	<input type="checkbox"/> Down's Syndrome
General Comments/Other	

ALLERGIES

<input type="checkbox"/> Eggs (<input type="checkbox"/> Epipen)	
<input type="checkbox"/> Milk (<input type="checkbox"/> Epipen)	<input type="checkbox"/> Soy (<input type="checkbox"/> Epipen)
<input type="checkbox"/> Peanuts (<input type="checkbox"/> Epipen)	<input type="checkbox"/> Bee Stings (<input type="checkbox"/> Epipen)
<input type="checkbox"/> Tree nuts (<input type="checkbox"/> Epipen)	<input type="checkbox"/> Penicillin (<input type="checkbox"/> Epipen)
<input type="checkbox"/> Fish (<input type="checkbox"/> Epipen)	<input type="checkbox"/> Hay Fever (<input type="checkbox"/> Epipen)
<input type="checkbox"/> Shellfish (<input type="checkbox"/> Epipen)	
Other Food Allergies	
Other Food Restrictions	

Office Use Only:

Staff Administration Epipen Form: _____ Date _____

AUTHORIZED PICK UP/EMERGENCY CONTACT

Authorized Person 1		Authorized Person 2	
Name:		Name:	
Relationship:		Relationship:	
Emergency Contact: Yes/No		Emergency Contact: Yes/No	
Phone Number:		Phone Number:	
Authorized Person 3			
Name:		Relationship:	
Emergency Pick Up: Yes/No		Phone Number:	
Parent/Guardian Signature:			
Emergency Contact			
Name:		Phone Number:	
Relationship:		Relationship:	
Name:		Name:	
Relationship:		Relationship:	