HEALTH INFORMATION FORM

Student Name (Last, First)_____

Parent/Guardian Name _____

Home Phone Number _____

Mobile Number _____

Emergency Contact Person _____

Medications the student is taking _____

_____

Allergies _____

_____

_____

Specific Health Concerns/considerations_____

_____

_____

Insurance Company _____

Policy Number_____

COVID Vaccination Status - Copy of Vaccine Card or results of a PCR test administered no more than 5 days prior to the clinic must be attached with this form

Authorization for Treatment

I, _____ (parent/guardian) of _____ (student) hereby authorize any necessary medical treatment needed in my absence. The undersigned will be responsible for any charges incurred for medical treatment under this authorization.

_____ _____

(Parent/Guardian Signature) (Date)