

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 _____

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)