

GILMER ISD  
STUDENT HEALTH RECORD

Student Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Sex: M / F Grade: \_\_\_\_\_

Parent/Guardian (Person to contact in case of emergency): \_\_\_\_\_

Relationship: \_\_\_\_\_ Address: \_\_\_\_\_

Phone #'s: Home: \_\_\_\_\_ Cell: \_\_\_\_\_

If I cannot be reached you may also contact:

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Relationship: \_\_\_\_\_

Preferred Hospital: \_\_\_\_\_ Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_

In case of accident or sudden illness to the above-named child and, in the event I cannot be reached by phone, I hereby authorize a representative of Gilmer ISD to refer this child for treatment.

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> *Allergic to Medication/Food     | <input type="checkbox"/> Digestive Problems      | <input type="checkbox"/> Psychiatric Disorders |
| <input type="checkbox"/> Asthma                           | <input type="checkbox"/> Headaches/Migraines     | <input type="checkbox"/> Scoliosis             |
| <input type="checkbox"/> Behavioral                       | <input type="checkbox"/> Hearing/Vision Problems | <input type="checkbox"/> Seizures              |
| <input type="checkbox"/> Blood disorders (i.e. Hepatitis) | <input type="checkbox"/> Heart/Cardiac           | <input type="checkbox"/> Other                 |
| <input type="checkbox"/> Cancer                           | <input type="checkbox"/> High Blood Pressure     | <input type="checkbox"/> Chick pox             |
| <input type="checkbox"/> Diabetes                         | <input type="checkbox"/> Kidney Problems         | Date Of Illness: _____                         |

**HEALTH HISTORY** - Please check any health conditions that apply to your child:

Please explain any boxes that were checked above: \_\_\_\_\_

**\*Please list Medication/Food Allergies and complete the Food Allergy Form:** \_\_\_\_\_

Daily/Routine Medications: \_\_\_\_\_

**ANY MEDICATIONS TO BE TAKEN/ADMINISTERED AT SCHOOL MUST BE BROUGHT TO SCHOOL BY A PARENT/GUARDIAN AND MUST BE IN THE ORIGINAL CONTAINER**  
(Please see your campus nurse for additional necessary consent forms.)

Major Illness, Surgical Procedures, Hospitalizations: \_\_\_\_\_

Disabilities/Handicaps: \_\_\_\_\_

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Signature of Parent/Guardian

Date