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.

- ☐ *Allergic to Medication/Food
- ☐ Asthma
- ☐ Behavioral
- ☐ Blood disorders (i.e. Hepatitis)
- ☐ Cancer
- ☐ Diabetes
- ☐ Digestive Problems
- ☐ Headaches/Migraines
- ☐ Hearing/Vision Problems
- ☐ Heart/Cardiac
- ☐ High Blood Pressure
- ☐ Kidney Problems
- ☐ Psychiatric Disorders
- ☐ Scoliosis
- ☐ Seizures
- ☐ Other
- ☐ Chick pox

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: _____

Signature of Parent/Guardian Date