Name: _____
(Last) (First) (Middle) (Preferred/nickname)
M F Date of Birth _____ Age_____ Grade_____ Homeroom Teacher_____
Custodial Parent/Legal Guardian with whom student has Primary Residence:
Name:_____Relationship:_____Home #:_____Cell #:_____
_____ Work #:_____
Address (Street, City, ST, Zip code)
Siblings (please list): _____
Alternate Adult Contacts: in case of emergency, I hereby authorize HSSD to allow my child to leave school only with the parent or legal guardian(s) listed above or the following persons:
Name: _____1. _____ 2. _____ 3. _____
Relationship Contact Phone Numbers
Doctor Name: _____ Phone:_____ Dentist Name: _____

Assessment of Student's Health

To the best of your knowledge, has your child had any problem with the following? Please check yes or no.

Condition	Yes	No	Comments if "Yes"
Allergies (food, insects, drugs, etc.)			
Allergies (seasonal)			
Asthma or breathing problems			
ADHS/ADD			
Behavioral Problems			
Bladder/Kidney Problems			
Bleeding/Clotting Problems			
Bowel Problem			
Cerebral Palsy			
Cholesterol			
Cystic Fibrosis			
Dental Problems			
Developmental Problems			
Diabetes			
Downs Syndrome			
Dyslexia/Learning Disorder			
Emotional problems			
Head, Spinal Injury, Concussion			
Headaches/Migraines			
Hearing Problems/Deafness			
Heart Problems/Murmur			
Hospitalizations (when, why)			
Hypertension (high blood pressure)			
Muscular/Orthopedic Problems			
Nutritional Problems			
Overweight			
Premature At Birth			
Psychological/Psychiatric (anxiety, depression)			
Seizures/Epilepsy			
Sickle Cell Disease (not trait)			
Special Diets			
Speech Problems			
Surgery			
Underweight			
Vision Problems			
Other:			

List all prescription and over-the-counter medications your child takes regularly:

_____

Please note any other concerns of which the school needs to be aware: _____

_____

_____Yes _____ No I give the school nurse permission to contact my child's physician or dentist should it become medically necessary.

Signature of Parent or Legal Guardian: _____Date_____