



HEALTH INFORMATION

2019-2020

TO BE COMPLETED BY PARENT/GUARDIAN EACH SCHOOL YEAR

PART 1 Parent/Guardian to Complete.

Student Name Last, First, Middle		☐ Male ☐ Female	DOB
Address		Home Phone Number	Grade/Teacher
Father	Father Cell Phone	Father Work Place	Father Work Phone
Mother	Mother Cell Phone	Mother Work Place	Mother Work Phone
Health Care Provider Name		Hospital Preference	
Emergency Contact #1 (Name NOT Listed Above)		Cell Phone	Work Phone
Emergency Contact #2 (Name NOT Listed Above)		Cell Phone	Work Phone

PART 2 Student's Health Information

☐ FOOD INTOLERANCE/RESTRICTIONS		List Food(s):	
☐ ALLERGIES: Check Type of Allergy and Reaction Type			
☐ Food	Name of Food(s):		
☐ Medication	Name of Medication(s):		
☐ Insect Sting	Type of Insect(s):		
☐ Other (List)			
Allergy Reaction Type	☐ Mild	☐ Severe/LIFE-THREATENING	
Allergy Medicine	☐ Oral Antihistamine (Benadryl, etc.)	☐ Epinephrine /EpiPen	☐ Other:
☐ ASTHMA	Triggers	☐ Exercise	☐ Environmental ☐ Illness ☐ Other (list)
Current Asthma Medications/Treatments		☐ Inhaler	☐ Nebulizer ☐ Oral Medication (Pills)
☐ DIABETES	☐ Type 1	☐ Insulin Pen	☐ Insulin Pump ☐ Type 2 ☐ Oral Medication (List):
☐ SEIZURE DISORDER	Date of Last Seizure:		Date of Last Hospitalization:
Symptoms	☐ Staring	☐ With Fever	☐ Convulsions (type): ☐ Other:
Current Seizure Treatment	☐ Oral (pills)	☐ Nasal	☐ Rectal ☐ VNS
☐ OTHER HEALTH CONDITIONS: Check all that apply			
☐ ADD/ADHD	☐ Heart Condition (Explain):		
☐ Blood Disorder	☐ Physical Disability (Explain):		
☐ Cancer (Explain):	☐ Other (Explain):		
CURRENT MEDICATIONS	(List)		
☐ Medication Needed AT SCHOOL (Permission Form Required)		List Medication/s:	
VISION	☐ Glasses	☐ Contacts	☐ Other: HEARING ☐ Hearing Loss ☐ Hearing Aid

PART 3 EMERGENCY AUTHORIZATION/CONSENT FOR OKLAHOMA STATE IMMUNIZATION INFORMATION SYSTEM

- I, the undersigned, do hereby authorize officials of the Enid Public Schools to contact directly the persons named on this form and do authorize the above named physician to render such treatment as may be deemed necessary in an emergency, for the health of above named child.
- In the event that physicians, other persons named on this form, or parents cannot be contacted, the school officials are hereby authorized to take whatever action is deemed necessary in their judgment, for the health of aforesaid child.
- I will not hold the school district financially responsible for the emergency care and/or transportation for said child.
- I give permission for the above health information to be released to school personnel necessary to ensure my child's health and safely while at school.
- I hereby authorize the Oklahoma Immunization Service to release my child's Immunization records and information located within the Oklahoma State Immunization Information System ("OSIIS") to Enid Public Schools as needed to verify my child's immunization status.

Parent Signature:

Date: