

**First Branch Unified District  
CHELSEA Campus TUNBRIDGE Campus  
STUDENT HEALTH INFORMATION**

Please complete this form **each year** to update the school nurse: My School \_\_\_\_\_

**Information provided is confidential.**

Child's full name \_\_\_\_\_ Birth Date \_\_\_\_\_ Grade \_\_\_\_\_  
Home Phone \_\_\_\_\_ Mailing Address \_\_\_\_\_

Mother's name \_\_\_\_\_ Occupation \_\_\_\_\_  
Work Phone: \_\_\_\_\_

Father's name \_\_\_\_\_ Occupation \_\_\_\_\_  
Work Phone \_\_\_\_\_

Emergency Contact (1): \_\_\_\_\_ Phone \_\_\_\_\_

Emergency Contact (2): \_\_\_\_\_ Phone \_\_\_\_\_

Physician's Name \_\_\_\_\_ Phone: \_\_\_\_\_

Date of last well-child/physical exam \_\_\_\_\_

Did your child receive any immunizations over the summer? (circle) Yes No

Dentist's Name \_\_\_\_\_ Phone: \_\_\_\_\_

Date of last visit? \_\_\_\_\_

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In case of an emergency, please understand that the school may call an ambulance and that ambulance personnel choose the most appropriate hospital for transport.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Occasionally the school nurse needs to contact your child's physician regarding immunizations, medication or other significant health or educationally pertinent medical information. By signing below, I consent to the release of the medical records of my child. I understand this authorization will expire at the end of the school year unless I specify otherwise.

Signature: \_\_\_\_\_ Relationship to Student: \_\_\_\_\_ Date: \_\_\_\_\_

PLEASE BE SURE TO COMPLETE BOTH SIDES OF THIS FORM

Health Form Page 2 of 2  
**CONFIDENTIAL HEALTH FORM**  
**Current Health**

Diet/Allergy/Medical Concerns:

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Current Mental Health Concerns:

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Is your child in counseling? Yes \_\_\_ No \_\_\_ If so , with whom \_\_\_\_\_

Is your child on any medications? Yes \_\_\_ No \_\_\_ If yes, please list medications below and be sure to include any emergency medications such as inhalers, epi-pen, Benadryl, etc.

Medication \_\_\_\_\_ Reason \_\_\_\_\_ Dose \_\_\_\_\_ Time Given \_\_\_\_\_

Medication \_\_\_\_\_ Reason \_\_\_\_\_ Dose \_\_\_\_\_ Time Given \_\_\_\_\_

Does your child have asthma? Yes \_\_\_ No \_\_\_

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Do you have medical insurance? Yes \_\_\_ No \_\_\_

If so, name of insurance company \_\_\_\_\_

If the answer is no, may a community resource person contact you? Yes \_\_\_ No \_\_\_

Other specialists your child may visit \_\_\_\_\_ Date of last visit \_\_\_\_\_

Does your child have any need of special attention?

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For example - Hearing? \_\_\_Yes \_\_\_No Glasses? \_\_\_Yes \_\_\_No

Does your child eat well? \_\_\_Yes \_\_\_No Does your child sleep well? \_\_\_Yes \_\_\_No

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My child has permission to take acetaminophen (Tylenol) at school if needed. \_\_\_Yes \_\_\_No

My child has permission to take ibuprofen (Advil) at school if needed. \_\_\_Yes \_\_\_No

I understand that when the School Nurse is not present, medications are given by non-medical personnel trained by the School Nurse.

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Dated

Revised August 3, 2018