



Health Form

Student Name:

1. Parent/Guardian 1 Name:
Phone:
2. Parent/Guardian 2 (optional) Name:
Phone:
3. Emergency Contact (other than parent): *We will always attempt to contact the parents first unless otherwise noted.*
Name:
Relation:
Phone:
4. Family Medical Insurance Carrier
Carrier:
Policy #:
5. Physician Name:
Phone #:
6. **Immunization Records:** All students must be current on all immunizations. You will need to have immunization date. Include a copy of immunization records. Provide date (month/year) of student's last tetanus (Tdap or DTP) shot:
7. **Health Information:** provide information on any medical conditions, psychological conditions, behavioral conditions, medications, dietary restrictions, allergies, or special needs that we need to be aware of to ensure that your child's school experience is positive.
8. Does your child have a health condition which may require EMERGENCY ACTION while he/she is at school? (*e.g. diabetes, seizure, severe allergic reaction/anaphylaxis to food or insect sting, , Asthma, Bleeding Problems, Heart Problems, etc.*)
If yes, describe:
 - a. Does your child have any Allergies?
 - b. Does your child have an allergy that requires an Epi-Pen and/or Benadryl?
 - c. Does your child have asthma and require an inhaler?
 - d. Is your child taking any medications? This includes any and all emergency medications including but not limited to: epi-pen, inhaler, Benadryl, any and all medications, prescription or over-the-counter, homeopathic, that your child will be carrying with them while attending school. Please include any medications your child will be taking while attending school, even for overnights.
 - a. If yes, enter medications:
 - i. medication:
 - ii. name:
 - iii. reason:
 - iv. dosage:
 - v. instructions:
9. Do you have a current allergy action plan and/or medication administration authorization form for any medications or emergency medications listed above?
10. Are there any reasons, medical or otherwise, that restrict your child from fully participating in any school activities? If yes, explain:
11. Any Special Considerations (dietary, behavioral, psychological, special needs that are relevant)? If yes, explain:

Authorize and Confirm:

This Health history is correct as far as I know and the person herein described has permission to engage in all prescribed school activities except as noted. This form may be photo copied for trips off-campus.

I hereby give permission for Five Stars Academy to secure and administer treatment, including hospitalization, administer medications and photo copy Health Form for trips out of school. Guardian is responsible for contacting Five Stars Academy if any of the described Health history changes.

Date:

Signature: