HEALTH INFORMATION FORM

Student's Name: Birthdate: Age: Gender:

Home Address: City: Zip:

Mother's Name: Saturday Phone:

Father's Name: Saturday Phone:

EMERGENCY: If parents cannot be reached, contact:

Name: Phone: Relationship:

Physician: Phone:

Regular Medications:

Date of last physical exam:

Does this child have any specific health problems, which the staff should be aware of?
(e.g. vision or hearing loss, allergies, drug reactions, convulsions, etc.) If "YES," please explain:

Has your child had any serious illnesses, accidents, surgeries, or communicable diseases?
If "YES", please explain:

Insurance Coverage (Company):

Group Number: Membership Number:

CONSENT FOR MEDICAL CARE AND TREATMENT OF MINOR CHILDREN

I, the natural parent/legal guardian of authorize and consent to medical, surgical, and hospital care, treatment, and procedures to be performed for my child by a licensed physician or hospital when deemed immediately necessary or advisable by the physician to safeguard my child's health and I cannot be contacted. I waive my right of informed consent to such treatment.

Signature of Parent/Guardian for 2017-2018: Date:

This consent statement has been approved by the Seattle Area Hospital Council and should be acceptable in an area hospital. Completed form remains in the school office.

I certify that this year the above information is still current: (Parent signature next to current school year

2018-2019:

2019-2020:

2020-2021:

2021-2022: