Emergency Information and Student Health History

Please fill in the following information:

Student's Name: _____ **Birthdate:** _____

Grade: ____ **Gender:** _____ **School:** _____

Home Phone # _____**Work #**_____ **Cell #**_____

Doctor's Name (Optional): _____

Doctor's Phone (Optional): _____

Emergency Contact Name: _____

Emergency Contact #'s: Home #_____ **Work or Cell #**_____

Life Threatening Allergies: **Yes No** _____

Other Allergies: **Yes No** _____

Asthma: **Yes No** _____

Diabetes: **Yes No** _____

Seizures: **Yes No** _____

Physical Restrictions: **Yes No** _____

Emergency Care Plan **Yes No** _____

Names of Medication: _____

(If taken at school, doctor's verification will be needed.)

Severe Food Allergy Disclaimer
Summit Hill School District #161

Does your son or daughter have a severe, life threatening, food related allergy?

Yes _____ No _____

If yes, please explain below:

_____

_____

_____

_____

Please be sure that all food allergy forms in accordance with Summit Hill School District #161 and Public Act 96-0349 have been filled out by yourself and your son or daughter's doctor, and that a copy of those records are on file with his or her school nurse, athletic director, and his or her coach at Summit Hill Junior High or Hilda Walker Intermediate School.

_____ _____

Parent / Guardian Signature **Date**