

STUDENT NAME _____ DATE OF BIRTH _____

MONACHE HIGH SCHOOL
EMERGENCY MEDICAL AND HEALTH HISTORY INFORMATION

ADDRESS _____

HOME PHONE _____ PARENT WORK/CELL PHONE _____ PARENT WORK/CELL _____

ARE THERE ANY PHYSICAL LIMITATIONS THAT SHOULD BE KNOWN?

HISTORY OF ANY OF THE FOLLOWING ILLNESSES OR ALLERGIES.
CHECK ALL THAT APPLY

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| <input type="checkbox"/> ASTHMA | <input type="checkbox"/> KIDNEY TROUBLE | <input type="checkbox"/> PLANT ALLERGIES* | <input type="checkbox"/> MEDICATION ALLERGIES* |
| <input type="checkbox"/> EPILEPSY | <input type="checkbox"/> DIABETES | <input type="checkbox"/> CONVULSIONS | <input type="checkbox"/> INSECT BITE ALLERGIES* |
| <input type="checkbox"/> HEART TROUBLE | <input type="checkbox"/> FAINTING SPELLS | <input type="checkbox"/> NOSEBLEEDS | <input type="checkbox"/> FOOD ALLERGIES* |
| <input type="checkbox"/> SINUS INFECTION | <input type="checkbox"/> HERNIA (RUPTURE) | <input type="checkbox"/> CRAMPS | <input type="checkbox"/> RHEUMATIC FEVER |
| <input type="checkbox"/> APPENDICITIS | <input type="checkbox"/> BRONCHITIS | <input type="checkbox"/> OTHER (PLEASE LIST) | |

PLEASE LIST ALL MEDICATIONS THE CHILD IS PRESENTLY TAKING

NAME OF MEDICATION	DOSAGE	TIMES TAKEN
_____	_____	_____
_____	_____	_____
_____	_____	_____

DATE OF LAST TETANUS INJECTION _____ DATE OF LAST MEDICAL EXAM _____
WEAR GLASSES OR CONTACT LENSES _____ WEAR BRACES _____

**IF AN EMERGENCY SHOULD ARISE WHICH REQUIRES IMMEDIATE MEDICAL ATTENTION, AND I /GUARDIANS
ARE UNABLE TO GIVE MY CONSENT OR MY NEAREST RELATIVE CANNOT BE CONTACTED YOU ARE
AUTHORIZED TO INITIATION WHATEVER STEPS ARE NEEDED TO PROTECT MY CHILD'S HEALTH**

SIGNED _____ DATE _____
PARENT/GUARDIAN

NEAREST RELATIVE TO CONTACT IN CASE OF EMERGENCY

NAME	ADDRESS	RELATIONSHIP	PHONE
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EMERGENCY CONTACT IF NEAREST RELATIVE IS NOT AVAILABLE

NAME	ADDRESS	RELATIONSHIP	PHONE
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NAME OF PHYSICIAN _____ PHONE _____

PERSONAL MEDICAL INSURANCE (1) _____ POLICY # _____

(2) _____ POLICY # _____