St. Michael School Health Form

Student Information

1. **Student Name:** _____
2. **Date of Birth:** _____
3. **Grade:** _____
4. **Medical Record Number:** _____

Emergency Contact Information

1. **Parent/Guardian Name:** _____
2. **Relationship to Student:** _____
3. **Phone Number:** _____
4. **Alternate Phone Number:** _____

Health History

Please provide information on any existing health conditions, allergies, or medications the student is currently taking.

Medical Conditions:

Allergies:

Current Medications:

Immunization Record:

Date of Last Physical Exam: _____

Authorization for Emergency Medical Treatment

I hereby authorize St. Michael School to obtain emergency medical treatment for my child in case of injury or illness when I cannot be reached. I understand that efforts will be made to contact me as soon as possible.

Parent/Guardian Name: _____

Parent/Guardian Signature: _____ **Date:** _____

Insurance Information

Insurance Provider: _____
Policy Number: _____
Group Number: _____

Healthcare Provider Information

Name of Primary Healthcare Provider: _____
Healthcare Provider Phone Number: _____

Additional Comments or Concerns
