MECDHH / GBSD
Health Form
2019-2020 School Year

Student's Name_____ **Date Completed**_____

Before your child can start school, this form must be completed each year and returned by August 30 and attach any additional sheets if necessary. **Note:** Please make a copy of your completed form and keep for your records.

DATA BASE To be completed by parent(s) or guardian. (***Please Print***)

Date of Birth_____ Sex M_____ F_____ Grade in September 2019_____

Student resides with: Both Parents _____ Father _____ Mother _____ Other _____

Parent/Guardian Name _____Cell _____ Alt. Phone _____

Address _____

Parent/Guardian Name _____Cell _____ Alt. Phone _____

Address _____

List two responsible adults, preferably in the area, to be contacted in case of emergency if parent/guardian is unavailable.

Name/Relationship _____ Cell _____ Alt. Phone _____

Name/Relationship_____ Cell _____ Alt. Phone _____

HEALTH INSURANCE MaineCare # _____

Name of other insurance company _____ Phone _____

Policy # _____ I.D. # _____ and/or Group # _____

Policy Holder's Name: _____

STUDENT PROFILE (**Use space on back of form, or attach a separate document, to explain**)

1. Any known allergies (include reaction to insect bites) Yes _____ No _____
   If yes, list allergy and type of reaction _____
2. Medications which student currently takes on a regular basis, both at home and at school. (Please complete the attached *PERMISSION TO ADMINISTER MEDICATION AT SCHOOL* form. Make copies as necessary to fill out one form for EACH medication to be given at school.)
   _____
3. Pertinent medical histories (e.g. asthma, diabetes, seizures, etc.)
   _____
4. Significant injury/illness since completion of last year's form (e.g. chicken pox, broken bones, mono, etc.)
   _____
5. Date of last physical exam _____ Date of last tetanus shot _____
6. Student's Primary Care Physician Name _____ Phone _____
   Other Physician Name _____ Specialty _____ Phone _____

AUTHORIZATION FOR TREATMENT: In the event I cannot be reached, I authorize that medical and/or surgical treatment be secured as may be deemed necessary or advisable for my child. I also authorize release of medical information to insurance companies for the purpose of payment and to health care providers who may treat my child.

Signature of Parent/Guardian* _____

*The parties agree that the electronic signature of a party to this Agreement shall be as valid as an original signature of such party and shall be effective to bind such party to this Agreement.