

## APPLICATION FOR HEALTHY STUDENT PROGRAM MEMBERSHIP 2018 - 2019

Student Name \_\_\_\_\_ Sex \_\_\_\_\_ Grade \_\_\_\_\_ DOB \_\_\_\_\_  
 (Last, First, MI)

Student # \_\_\_\_\_ Home Address \_\_\_\_\_ Home Phone \_\_\_\_\_

PERSON TO BE CONTACTED IN CASE OF EMERGENCY:

Parent Name	Place of Business	Business Phone	
Backup Person to be Called		Home Phone #	Cell Phone #

### STUDENT MEDICAL HISTORY

List any ALLERGIES to Medications or Food: \_\_\_\_\_

List any SURGERY/HOSPITALIZATION: \_\_\_\_\_

List any CURRENT MEDICATIONS: \_\_\_\_\_

List any MEDICAL / HEALTH PROBLEMS: \_\_\_\_\_

**FAMILY MEDICAL HISTORY:** (Circle all that apply and indicate which family members have or have had the condition)

High Blood Pressure \_\_\_\_\_ Tuberculosis \_\_\_\_\_ Diabetes \_\_\_\_\_

Epilepsy \_\_\_\_\_ Sickle Cell \_\_\_\_\_ Cancer \_\_\_\_\_

Heart Problems \_\_\_\_\_ Asthma \_\_\_\_\_ Arthritis \_\_\_\_\_

Name of Family Physician \_\_\_\_\_ Phone \_\_\_\_\_

Name of Family Dentist \_\_\_\_\_ Phone \_\_\_\_\_

Date of Student's Last Physical Exam \_\_\_\_\_ Last Dental Exam \_\_\_\_\_

### ENROLLMENT STATEMENT

We agree to enroll \_\_\_\_\_ in the Healthy Student Program. We understand that the program offers a limited range of HEALTH COUNSELING services on an as-needed basis. We further understand that these services DO NOT REPLACE the services of our family doctor. In case of accident or serious illness, the school policies outlined on the School's Emergency Information Card will be observed. We further understand that student information is confidential except in those instances when professionals are required by law to report child abuse, death threats, suicide risk, and public health concerns.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_