

**Concord Carlisle High School  
Health Office Information Card**

Student: \_\_\_\_\_ Student ID#: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Grade: \_\_\_\_\_ Teacher/HR: \_\_\_\_\_

Address: \_\_\_\_\_ Legal Guardian: \_\_\_\_\_

Living Arrangement:  Mother  Father  Both  Other: \_\_\_\_\_

Health Insurance:  Yes  No Dental Insurance:  Yes  No

Doctor: \_\_\_\_\_ Tel.#: \_\_\_\_\_ Dentist: \_\_\_\_\_ Tel.#: \_\_\_\_\_

If medical emergency situations arise, we want to respond according to your wishes. Please provide the following information and indicate the order in which the people should be contacted.

( ) **Father's name:** \_\_\_\_\_ Cell#/Car#: \_\_\_\_\_

Home Address: \_\_\_\_\_ e-mail: \_\_\_\_\_ Home Tel.#: \_\_\_\_\_

Work Name: \_\_\_\_\_ City: \_\_\_\_\_ Work Tel.#: \_\_\_\_\_

( ) **Mother's name:** \_\_\_\_\_ Cell#/Car#: \_\_\_\_\_

Home Address: \_\_\_\_\_ e-mail: \_\_\_\_\_ Home Tel.#: \_\_\_\_\_

Work Name: \_\_\_\_\_ City: \_\_\_\_\_ Work Tel.#: \_\_\_\_\_

Please list 2 neighbors and/or relatives whom we may call, or to whom we may release your child in an emergency.

( ) Name: \_\_\_\_\_ Address: \_\_\_\_\_ Tel.#: \_\_\_\_\_

( ) Name: \_\_\_\_\_ Address: \_\_\_\_\_ Tel.#: \_\_\_\_\_

1/03

I authorize the school or delegate to administer the following medication according to school medication protocol:

Acetaminophen (Tylenol)  Yes  No

Ibuprofen (Advil)  Yes  No

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

Health History/School Health Concerns: \_\_\_\_\_

Asthma:  Yes  No Describe Treatment: \_\_\_\_\_

Allergy	Describe Reaction	Describe Treatment
Food:		
Medications:		
Other:		

Current Medications/Amount & Times @ Home: \_\_\_\_\_

**Release:**

I give my permission to exchange information with my child's primary care physician for the purpose of referral, diagnosis, and treatment.

**Release Signature:** \_\_\_\_\_ Date: \_\_\_\_\_

**OFFICE USE ONLY – PRN Medication:**
