MISD
Mansfield Independent School District

Student Health Information Form

Student Name: _____ DOB: _____ Student ID: _____
Address: _____
Campus: Mansfield High School Grade: Teacher: Ludlow/Dunbar/ Feldser

Parent/Guardian: _____ Relationship to Student: _____
Phone: (Best # during school day): _____(alt. #): _____E-mail: _____
Parent/Guardian: _____ Relationship to Student _____
Phone: (Best # during school day): _____(alt. #): _____E-mail: _____

Alternate contacts to call in case of an emergency and parents/guardians cannot be reached:
Name: _____ Relationship: _____ Phone: _____
Name: _____ Relationship: _____ Phone: _____
Name: _____ Relationship: _____ Phone: _____

Physician Name: _____ Phone: _____ Preferred Hospital: _____
Student's Health Insurance: _____

Indicate if your child has any of the following health conditions:

ADD/ADHD	☐	Cystic Fibrosis	☐	Migraine Headaches	☐
Allergy: Food**	☐	Diabetes	☐	Muscular/Orthopedic Disorder	☐
Allergy: Insect Bite/Sting	☐	Eating Disorder	☐	Psychiatric/Psychological Disorder	☐
Allergy: Other	☐	Epilepsy/Seizures	☐	Special Needs	☐
Asthma	☐	Hearing Condition	☐	Vision Loss-not corrected with glasses/contacts	☐
Blood Disorder	☐	Heart Condition	☐	Chicken Pox-month/day/year _____	☐
Cerebral Palsy	☐	Kidney Disorder	☐		

** Parent must provide the MISD Student Nutrition office with a note from the doctor for any special dietary considerations regarding school lunches.

If you checked any of the boxes above, or if your child has medical conditions not listed, please explain (including **specific food, medication or other serious allergies and reactions)**: _____
_____
Past history of injuries/illnesses/hospitalizations/surgeries: _____
_____

Please list all medications your child is currently taking:

Medication Name _____ Dose _____ Reason _____
Medication Name _____ Dose _____ Reason _____
Medication Name _____ Dose _____ Reason _____

It may be necessary for school personnel to apply topical first aid medications such as: anti-itch cream, antibiotic ointment, tooth pain gel, saline eye drops. If you do not want your child to receive these services enter "no" on the line following. Otherwise it is understood that you are giving permission for school personnel to apply first aid medications. ____

I, the undersigned, do hereby authorize officials of the Mansfield Independent School District to contact alternative adults and physicians listed. I authorize the school nurse, or trained personnel, to render treatment deemed necessary in case of an emergency. I authorize medical information to be shared with appropriate personnel. I will not hold Mansfield ISD financially responsible for the emergency care and/or transportation of said child.

_____ _____
SIGNATURE OF PARENT/GUARDIAN **DATE**