



Student with Existing/ Identified Health Problem

Student Name _____

Address _____ City _____ State _____ Zip _____

Date of Birth _____ Male Female Grade _____ Phone _____

This form is for students with identified health problems such as: asthma, seizures, hemophilia, etc., and will be placed in the students file and a copy provided to the teacher.

Condition: _____

Symptoms: (State most obvious signs that would appear if student were having difficulty)

1. _____
2. _____
3. _____

Immediate Action: (State action necessary to be taken to best respond to student immediate needs)

1. _____
2. _____
3. _____

Secondary Action: (Once immediate crisis is past, persons to call, signs to watch for, etc.— if none state none)

1. _____
2. _____
3. _____

Mother's Name _____	Day Phone _____	Cell _____
Father's Name _____	Day Phone _____	Cell _____
Please list two available alternates to attempt to contact in an emergency:		
1. (name/relationship to student) _____	Day Phone _____	
2. (name/relationship to student) _____	Day Phone _____	
Physician Name _____	Clinic Name _____	
Phone: Clinic _____	Physician's Emergency Phone _____	
Dentist Name _____	Clinic Name _____	
Phone: Clinic _____	Dentist's Emergency Phone _____	