Student Emergency and Health Information

Teacher: _____Grade: _____

*** If Custody Restrictions Apply (Court Documents are Required)**

THIS INFORMATION IS CONFIDENTIAL BUT SHARED WITH APPROPRIATE SCHOOL PERSONNEL

STUDENT'S FULL LEGAL NAME:				FEMALE ☐ MALE ☐
	LAST	FIRST	MIDDLE	DOB

STUDENT HOME ADDRESS:		PHONE	
	STREET CITY ZIP CODE		

STUDENT LIVES WITH: (CIRCLE ONE) BOTH PARENTS MOTHER FATHER GUARDIAN

MOTHER: NATURAL / STEP / FOSTER (PLEASE CIRCLE ONE)		FATHER: NATURAL / STEP / FOSTER (PLEASE CIRCLE ONE)		GUARDIAN: (PLEASE PROVIDE COURT PAPERS)	
NAME:		NAME:		NAME:	
CELL NUMBER:		CELL NUMBER:		CELL NUMBER:	
PLACE OF EMPLOYMENT:		PLACE OF EMPLOYMENT:		PLACE OF EMPLOYMENT:	
WORK PHONE:		WORK PHONE:		WORK PHONE:	

If the parent/guardian cannot be reached, please enter contact information for the person(s) authorized to care for your child.
Only the contacts listed on this form may pick up your child with proper identification.

NAME:	RELATIONSHIP:	PHONE: (CELL)	(EMAIL)
NAME:	RELATIONSHIP:	PHONE: (CELL)	(EMAIL)
NAME:	RELATIONSHIP:	PHONE: (CELL)	(EMAIL)
NAME:	RELATIONSHIP:	PHONE: (CELL)	(EMAIL)
NAME:	RELATIONSHIP:	PHONE: (CELL)	(EMAIL)

CHECK ALL MEDICAL CONDITIONS THAT APPLY TO YOUR CHILD BELOW	LIST ALL CHILDREN IN FAMILY IN ORDER OF BIRTH:
☐ ADD/ADHD ☐ ASTHMA ☐ MIGRAINE ☐ EAR INFECTIONS	NAME (FIRST & LAST) AGE/SEX LIVING AT HOME GRADE SCHOOL
☐ HEARING AID ☐ HEARING LOSS ☐ GLASSES ☐ CONTACTS	·
☐ OTHER:	·
☐ DIABITES/ TYPE: TESTING AT SCHOOL: Y / N INSULIN: Y/N	·
☐ HEART DISEASE/KIDNEY DISEASE: ☐ SURGERY: Y OR N MEDICATION:	·
☐ SEIZURE/TYPE: MEDICATION: Y/N	·
ALLERGIES – ENVIORMENTAL: Y OR N FOOD: Y OR N EPI-PEN: Y/N LIST:	
LIST OF MEDICATIONS: HOME/SCHOOL/TIMES	

PARENT SIGNATURE_____ DATE_____ DOCTOR NAME_____PHONE: _____

Oasis Middle * 3507 Oasis Blvd. Cape Coral, FL 33914 * 239-945-1999 * FAX: 239-540-7677