



**HEALTH FORM** (All dates are in the form: month/day/year)

Student's Name \_\_\_\_\_ Entrance Date \_\_\_\_\_  
Birth Date \_\_\_\_\_  
Sex(Circle One): Male/Female Grade \_\_\_\_\_  
Student lives with: Both Parents \_\_\_ Father \_\_\_ Mother \_\_\_ Guardian \_\_\_ Other \_\_\_  
Father's Name \_\_\_\_\_ Mother's Name \_\_\_\_\_

Home Address \_\_\_\_\_  
Home Phone \_\_\_\_\_  
Business Address (father) \_\_\_\_\_  
Father's Work Phone \_\_\_\_\_  
Business Address (mother) \_\_\_\_\_  
Mother's Work Phone \_\_\_\_\_  
Father's Mobile Phone \_\_\_\_\_ Father's e-mail \_\_\_\_\_  
Mother's mobile phone \_\_\_\_\_ Mother's e-mail \_\_\_\_\_

Guardian's name in La Paz, if not living with  
parents \_\_\_\_\_  
Guardian's Relationship to  
Student \_\_\_\_\_  
Guardian's Work Phone \_\_\_\_\_ Guardian's Mobile Phone \_\_\_\_\_

Emergency Contact in La Paz (who will assume care for your child if you cannot be reached)  
Name \_\_\_\_\_ Home Phone \_\_\_\_\_ Mobile\ Phone \_\_\_\_\_  
Health Insurance (company's name) \_\_\_\_\_  
Preferred Doctor in La Paz \_\_\_\_\_ Phone Number \_\_\_\_\_  
Name of clinic we can take your child in case of an emergency \_\_\_\_\_

These forms must be completed and returned **within 60 days** following the beginning of the school year. If these forms are not completed by the due date, the student may not be allowed to attend school. If you change your address or phone numbers, you must notify the school with these changes.

\*Note: All students who participate in any school-related activities must have a current Medical Release/Parental Consent Form on file.

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



MEDICATION PERMISSION (All dates are in the form: month/day/year)

With your permission, the school nurse may administer the following medications:  
- Acetaminophen (Tylenol) for headache, fever, menstrual cramps or other minor discomfort.  
- Ibuprofen (Iprin, Advil) for inflammation or fever.  
- Sertal for minor stomachache.  
- Throat lozenge for mild sore throat or cough.  
- Topical ointments or solutions for minor wounds, skin irritations, and insect bites/stings

I give permission for the School Nurse to administer all the medications listed above.

Yes \_\_\_\_ No \_\_\_\_

I only give permission for the following medicines to be given (complete if needed).

\_\_\_\_\_

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

Date \_\_\_\_\_

HEALTH HISTORY REVIEW

Please read carefully and circle the appropriate answer. Any "yes" response please explain in detail in the space provided .

- |                                                                         |        |
|-------------------------------------------------------------------------|--------|
| 1- Any injuries or illnesses requiring medical attention?               | Yes No |
| 2- Wears glasses or contact lenses?                                     | Yes No |
| 3- Any known drug or food allergies?                                    | Yes No |
| 4- Taking any medicine or under physician's care at this time?          | Yes No |
| 5- Any feeling of faintness, dizziness or fatigue after heavy exertion? | Yes No |
| 6- Any hospitalization, surgery or fracture?                            | Yes No |
| 7- Any health condition diagnosis?                                      | Yes No |
| 8- Any chronic disease?                                                 | Yes No |
| 9- History of convulsions?                                              | Yes No |
| 10- Any condition that may be exacerbated by playing sports?            | Yes No |
| 11- Any medication needed to be given by nurse during school hours?     | Yes No |

Please explain all "Yes" responses \_\_\_\_\_

\_\_\_\_\_

I hereby certify that the above medical information is accurate and current.

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

Date \_\_\_\_\_