STUDENT INFORMATION AND HEALTH FORM

ALL INFORMATION WILL BE TREATED WITH THE STRICTEST OF CONFIDENTIALLY.

STUDENT'S FULL LEGAL

NAME: ____
STREET ADDRESS: ____
CITY: ______________________ **STATE:** _________________ **ZIP:** __________
Date of Birth: _________________ **Age:** ____________
Male: __________ **Female:** __________
High School: ________________________________ **Grade:** __________________
Guidance Counselor Name: _______________________ **Phone Number:** ________

PARENT/GUARDIAN (S) FULL LEGAL NAME: __________________________
WORK PHONE: ____________________ **CELL:** __________________________
HOME: ________________________
Parents EMAIL: _______________________(further information will be email)
IN CASE OF EMERGENCY NOTIFY: __________________________________
PHONE: _____________________

Health Insurance Carrier: ____
Policy Holder's Name: ____

Food and/or Drug Allergies: ____

IN CASE OF EMERGENCY, I HEREBY GIVE MY PERMISSION FOR MEDICAL TREATMENT TO BE GIVEN TO THE ABOVE NAMED CHILD.

____ ____________________
Parent Signature **Date**

PLEASE PROVIDE A PHOTOCOPY OF THE ACTUAL HEALTH INSURANCE CARD AND COPY OF POLICYHOLDER IDENTIFICATION CARD.