CONROE INDEPENDENT SCHOOL DISTRICT
Committed to Excellence

Student Health Information

This information is for use by the school clinic to help care for your child until you can be reached if he/she becomes ill or injured, or if you cannot be reached by phone.

Student Name *(legal)* _____
Last *First* *Middle*

Sex ☐ male ☐ female Birthdate _____ Grade _____

Last school attended _____
Name of school *City* *State*

Has this student attended CISD school previously? ☐ yes ☐ no

If **yes**, name the last CISD school attended _____ Grade _____

Name of parent/guardian with whom the student lives _____

Address _____
street address *city* *zip* *subdivision/neighborhood/complex*

Relationship to child _____ Home phone number _____

Father/Guardian _____ _____ _____ _____
name *place of work* *work phone* *cell phone*

Mother/Guardian _____ _____ _____ _____
name *place of work* *work phone* *cell phone*

Name/address of person student lives with if not living at home with parent/guardian _____

Address _____
street address *city* *zip* *subdivision/neighborhood/complex*

Work phone number _____ Home phone number _____

Person to be called in case of emergency if parents cannot be reached:

		Home	***Work***	***Cell***
1. Name _____	Phone No.	_____	_____	_____
2. Name _____	Phone No.	_____	_____	_____
3. Name _____	Phone No.	_____	_____	_____

Physician's name _____ Phone number _____

Hospital _____ Phone number _____

Has your child had the Chicken Pox? ☐ yes ☐ no If yes, month _____ year _____

Are there any other concerns the school needs to be aware of?
Is your child on any medication the school needs to be aware of? If yes, please list below.

_____

_____

I understand the school will make every effort to contact me or the person(s) I have named above in case of emergency requiring a physician's care; however, if unable to make contact, school officials are hereby authorized to take whatever action is deemed necessary in their judgement, for the health of my child/charge. I also understand the school district has no financial responsibility for the emergency care or transportation in an emergency vehicle for my child/charge.

_____ _____
Parent/guardian signature *Date*

Does your child have any of the following conditions?
check all that apply

- ☐ Asthma
- ☐ Food allergy _____
  Nature of reaction _____
- ☐ Allergies *(other)* _____
- ☐ Seizure disorder
- ☐ Diabetes
- ☐ Heart problems
- ☐ Hearing problems
- ☐ ADD/ADHD

CISD-157 (9/11)