UME Preparatory Academy
Student Health Information Sheet

Student Legal Name _____ **DOB**_____ **Grade** _____
Address _____ **City** _____ **Zip** _____

Parent/Guardian _____ Relationship to Student _____
Phone # (1) _____ (2) _____ E-mail _____
Parent/Guardian _____ Relationship to Student _____
Phone # (1) _____ (2) _____ E-mail _____

Alternate contacts to call in case of an emergency and parents/guardians cannot be reached:
Name _____ Relationship _____ Phone #_____
Name _____ Relationship _____ Phone #_____
Name _____ Relationship _____ Phone # _____

Physician Name _____ Phone # _____
Preferred Hospital _____ Phone # _____
Insurance: None _____ Medicaid _____ Texcare _____ CHIP _____ Other _____

Please check, if condition has been diagnosed by a doctor:

- ☐ ADD/ADHD
- ☐ Allergy: Food**
- ☐ Allergy: Medication
- ☐ Allergy: Seasonal
- ☐ Asthma
- ☐ Blood Disorder
- ☐ Cerebral Palsy
- ☐ Chicken Pox (date of disease ___/___/_____) Mth Day Year
- ☐ Cystic Fibrosis
- ☐ Diabetes
- ☐ Down Syndrome
- ☐ Ear Infections
- ☐ Eating Disorder
- ☐ Epilepsy/Seizures
- ☐ Hearing Condition
- ☐ Heart Condition
- ☐ Kidney Disorder
- ☐ Meningitis
- ☐ Migraine Headaches
- ☐ Muscular/Orthopedic Disorder
- ☐ Psychiatric/Psychological Disorder
- ☐ Serious Injury/Accident
- ☐ Special Needs
- ☐ Vision Concerns
- ☐ Wears Corrective Lenses
- ☐ Other _____
- ☐ Other _____

Explain any condition checked above (use back of paper if needed): _____

** Parent must provide a note from the doctor for any special considerations regarding school lunches.

Past injuries/illnesses/hospitalizations/surgeries (use back of paper if needed): _____

Please list all medications your child is currently taking:
Medication Name _____ Dose _____ Reason_____
Medication Name _____ Dose _____ Reason_____
Medication Name_____ Dose_____ Reason_____

It may be necessary for school personnel to apply topical first aid medications such as: anti-itch cream, tooth pain gel, saline eye drops. ☐ Yes, I give permission for my child to have topical OTC medications except the ones listed above that they have had a previous allergic reaction to. ☐ No, do not apply any topical OTC medications.

I, the undersigned, do hereby authorize officials of UME Preparatory Academy to contact alternative adults and physicians listed. I authorize the school nurse, or trained personnel, to first aid as needed and/or treatment deemed necessary in case of an emergency. I authorize medical information to be shared with appropriate personnel. I will not hold UME Preparatory Academy financially responsible for the emergency care and/or transportation of said child.

_____ _____
SIGNATURE OF PARENT/GUARDIAN **DATE**