Williamson County Schools
Health History & Emergency Form

Grade in Fall :_____

Homeroom: _____

Student's Name: _____ Sex:_____ Date of Birth:_____

Address: _____ Home Phone:_____
Street City Zip

Mother/Guardian: _____ Work:_____ Cell: _____ Email:_____

Father/Guardian: _____ Work: _____ Cell: _____ Email : _____

Emergency Contact~ Name: _____Phone: _____ Cell:_____

Emergency Contact~ Name: _____Phone: _____ Cell:_____

* * * * * *

Pertinent health information would be used to help your child in case of an emergency:

Health Concerns/Medical Conditions:_____

_____

Medication Allergies:_____ Food Allergies:_____

Medications taken at school: _____

Medications taken at home: _____

Continue information on back as needed

* * * * * *

Name of Physician: _____ Phone: _____ Fax:_____

Name of Dentist: _____ Phone: _____Fax: _____

Preferred Hospital: _____ Phone: _____

I authorize my child to receive emergency medical treatment from a medical provider if he/she is seriously injured or ill while in school.

Relevant health information will be shared only as necessary to maintain and promote the student's health and safety.

_____ _____
Parent/Guardian Signature Date

Please return this form to your school nurse

IV-HEA-1
Rev. 3/04