







**HEALTH INFORMATION**

Primary address at which student lives:  _____ Number and Street or P.O. Box  _____ City State Zip Code	STUDENT _____ Last Name First Name Middle Name  Date of Birth: _____ / _____ / _____ Month Day Year  Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
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In case of **accident or sudden illness**, please provide the following:

**Parent/Guardian #1** \_\_\_\_\_  Mother  Father  Other \_\_\_\_\_

Home Phone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Work Phone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  Emergency Only

Cell Phone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Pager \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Parent/Guardian #2** \_\_\_\_\_  Mother  Father  Other \_\_\_\_\_

Home Phone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Work Phone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  Emergency Only

Cell Phone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Pager \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Physician Name** \_\_\_\_\_ **Phone** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Dentist Name** \_\_\_\_\_ **Phone** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Hospital Choice** \_\_\_\_\_ Are you on Medicaid?  Yes  No

Medical Insurance Company or HMO \_\_\_\_\_ Policy Number \_\_\_\_\_

**Do you require financial assistance for medical treatment or immunizations?**  Yes  No

List two **LOCAL** people who may temporarily care for the student if Parent/Guardian cannot be reached:

**Name** \_\_\_\_\_ Available:  During school hours  After school

Home Phone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Work Phone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  Emergency Only

Cell Phone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Pager \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Name** \_\_\_\_\_ Available:  During school hours  After school

Home Phone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Work Phone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  Emergency Only

Cell Phone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Pager \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

List any **significant or on-going health condition** (example: severe allergies/epi pen, asthma, ADD, birth defects, diabetes, epilepsy, heart disease, vision or hearing problem) or any other condition relevant to school, activities, or athletics.

Explanation \_\_\_\_\_

\_\_\_\_\_

Medications (taken on a regular basis)

At School: \_\_\_\_\_

At Home: \_\_\_\_\_

Medication/Food Allergies (Codeine, Fish, etc.) \_\_\_\_\_

**PARENT/GUARDIAN CONSENT**

Parents/Guardians are expected to arrange transportation for their student except in cases of dire emergency. In the event of acute illness, we shall attempt to notify the parents first. If none of the persons named above can be contacted, the school officials are hereby authorized to take whatever action, including the use of an ambulance, is deemed necessary in their judgement for the health of the student.

I, the undersigned, do hereby authorize officials of Boulder Preparatory High School or BVSD to contact directly the persons named above and do authorize the named physician or dentist to render treatment necessary in an emergency for the health of the student. In the event the named physician or dentist is not available during the emergency, I hereby authorize the next available physician or dentist to render treatment necessary for the health of the student.

I will not hold Boulder Preparatory High School or BVSD financially or legally responsible for providing emergency care and/or transportation for the student.

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