PEARSALL INDEPENDENT SCHOOL DISTRICT
HEALTH SERVICES

PARENT: PLEASE PROVIDE US WITH THE INFORMATION REQUESTED BELOW AND RETURN TO THE SCHOOL NURSE AS SOON AS POSSIBLE.

1. Student's Name:____ Date of Birth: ____________________

   Grade: _____Teacher: ________________ Home Phone: _______________ Cell Phone: _______________

   Home Address: __________________________ Mailing Address: _________________________________

   Last school(s) attended: ____

2. Parent's Name/Place of Employment:
   Father's Name: ______________________Employment: ___________________ Phone: _______________
   Mother's Name: _____________________Employment: ___________________ Phone: _______________

3. Who to contact in case parents are not available:
   Name: _____________________________Address: _______________________Phone: _______________
   Name: _____________________________Address: _______________________Phone: _______________

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4. Does your child have asthma as diagnosed by a physician? Yes ☐ No ☐

   Has your child had any allergic reactions to medications, foods or insects? Yes ☐ No ☐

   If yes, to either both questions please indicate medication prescribed: ______________________________

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   ____

5. Does your child have a seizure disorder diagnosed by a doctor? Yes ☐ No ☐
   If yes, please indicate medication prescribed? ____

6. Please list any other health conditions about your child that you feel we at the school need to know about

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7. In case of an accident and in the event I cannot be reached immediately by phone, I hereby authorize a representative of the Pearsall Independent School District to refer my child to Dr.______________________, or if said physician cannot be reached, then refer to Dr. ___________________.

_____________________________________ _____________________________

Parent/Guardian's Signature Date

THE ABOVE INFORMATION WILL BE SHARED WITH THE PRINCIPAL'S OFFICE AND STUDENT'S TEACHERS.

Intermediate/08