LIST NAMES OF CHILDREN AT HELIAS

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____
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STUDENT HEALTH AND EMERGENCY INFORMATION

1. FATHER/GUARDIAN ________________________________ HOME PHONE: _____________
   Employment: ____ WORK PHONE: _____________
   CELL PHONE: ____________

2. MOTHER/GUARDIAN________________________________ HOME PHONE: ______________
   Employment:____ WORK PHONE: ______________
   CELL PHONE: _____________

PERSONS TO CONTACT IF PARENTS ARE NOT AVAILABLE:

Name:______________________________ Relationship: ____________ Phone: ________Cell:________
Name: ______________________________ Relationship: ____________ Phone: ________Cell:________

Family Doctor: ____ Phone: ___________
Family Dentist: ____ Phone: ___________
Hospital Preference: ____ Phone: ___________
Health Insurance (Check):
Private/Group ______ Medicaid ____ No Health Insurance _______ HMO/Managed Care ________

AUTHORIZATION FOR SCHOOL OFFICIALS IN CASE OF EMERGENCY:
I authorize school officials to secure emergency treatment if I cannot be reached. I will assume responsibility for expenses incurred.
Date:____________________ Parent Signature: ____

PARENT E-MAIL INFORMATION: (only if changed)

Mom's E-Mail ________________________________

Dad's E-Mail _________________________________

STUDENT INFORMATION—*(To be completed for each student at Helias. Additional student information on back if you have more than one student attending Helias.)*

Name: __________________________________ Present Grade: _______ Birth date: ____________

Student Cell:__________________________

List health conditions or disabilities ____

List medications your child is allergic to ____
Other allergies (food, seasonal, band-aids, other) ____

Medication taken routinely ______________________________ as needed ___________________
Any vision/hearing problems? Yes / No (wears glasses, contacts, hearing aid)
Explain ____

Child has had a comprehensive physical exam in the last two years? Yes ________ No_________
Child has had a dental exam in the last year? Yes ______ No _______
Child has received an immunization or booster in the last year? Yes __ No __ Type _____ Date ______

2nd STUDENT INFORMATION

Name:____ Present Grade: ________ Birth date: _________

Student Cell: __________________________

List health conditions or disabilities ____

List medications your child is allergic to ____

Other allergies (food, seasonal, band-aids, other) ____

Medication taken routinely __________________________________ as needed _____________________

Any vision/hearing problems? Yes ______ No ______ (wears glasses, contacts, hearing aid)
Explain ____

Child has had a comprehensive physical exam in the last two years? Yes _____ No ______

Child has had a dental exam in the last year? Yes ______ No _______

Child has received an immunization or booster in the last year? Yes ___ No ___ Type ______ Date ______

3rd STUDENT INFORMATION

Name:____ Present Grade: ________ Birth date: _________

Student Cell: _____________________________

List health conditions or disabilities ____

List medications your child is allergic to ____

Other allergies (food, seasonal, band-aids, other) ____

Medication taken routinely __________________________________ as needed _____________________

Any vision/hearing problems? Yes ______ No ______ (wears glasses, contacts, hearing aid)
Explain ____

Child has had a comprehensive physical exam in the last two years? Yes _____ No ______

Child has had a dental exam in the last year? Yes ______ No _______

Child has received an immunization or booster in the last year? Yes ___ No ___ Type ______ Date ______