Dr. Sharon Roberts
Coordinator, Advanced Academic Services
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Mission CISD Health History

NAME_____ D.O.B_____

CAMPUS_____

PERSON TO NOTIFY _____ PHONE # _____

ALTERNATE _____ PHONE # _____

FAMILY DOCTOR _____ PHONE # _____

IN CASE OF AN EMERGENCY, I AUTHORIZE THE SCHOOL TO INITIATE EMERGENCY CARE (hydrogen peroxide, first aid cream, epinephrine, O^2, etc.) AT SCHOOL AND SEND THE STUDENT TO THE HOSPITAL OR DOCTOR IF PARENT OR GUARDIAN CANNOT BE REACHED. I UNDERSTAND THAT I WILL BE FINANCIALLY RESPONSIBLE. CIRCLE: YES NO

PREFERRED HOSPITAL:_____

INSURANCE: (Circle one) Medicaid CHIP Private Insurance No Insurance

SIGNED: _____ DATE _____
Parent

HEALTH HISTORY:
EXPLAIN ANY MEDICAL PROBLEMS AND MEDICATION NEEDED:
_____
_____
_____
_____

KNOWN ALLERGIES: To medication, food, insect bites, etc. _____
_____
_____
_____