KAMEHAMEHA SCHOOLS HAWAI`I

Elementary and Middle School Health Services Department

STUDENT INFORMATION

School Year 2015- 2016

Last Name	First	Middle Initial(s)	Birthdate	Grade

Address	City	State	Zip Code

PARENT/GUARDIAN INFORMATION	
Call First: ❒Mother ❒Father ❒Other:	**Call Second: ❒Mother ❒Father ❒Other:**
Parent/Guardian Name:	**Parent/Guardian Name:**
Home Phone:	**Home Phone:**
Work / Business Phone:	**Work / Business Phone:**
Cell / Pager Number:	**Cell / Pager Number:**

EMERGENCY CONTACTS

(**Adults designated to pick up child when we are unable to contact parent**)

Name	Relationship	Home Phone	Work Phone	Cell / Pager
1.				
2.				
3.				
4.				

HEALTH INSURANCE INFORMATION

My Child has health insurance: ❒ No ❒ Yes if yes, please provide copy of insurance card

Medical Insurance Company:		**Policy or Member #:** (if applicable)	
Subscriber Name:		**Relationship to Student:**	
Subscriber Phone Numbers (if not listed above)	**Home:**	**Work:**	**Cell/Pager:**
Family Physician:			

MEDICAL INFORMATION

❒ **No Medical Conditions**

❒ **My child has allergies: (check all that apply)**

❒ Nasal Allergies ❒ Eye Allergies ❒ Skin Allergies ❒ Bee Stings

❒ Food Allergies (list):_____

❒ Medication Allergies (list):_____

❒ Other Allergies (list):_____

❒ **My child has the following condition(s): (check all that apply)**

❒ Asthma ❒ Cancer / Leukemia ❒ Cough / Wheezing ❒ Diabetes

❒ Hearing Problem ❒ Hemophilia ❒ Heart Disease ❒ Rheumatic Heart

❒ Vision Problems ❒ Seizures

❒ Other:_____

❒ **My child takes the following medication(s):**

Name of Medication*	Amount of Dose	When Taken	Reason for Medication

*If your child requires these medications during school hours, please contact the health room for additional forms

Print Name of Mother/Guardian	Signature of Mother/Guardian	Date

Print Name of Father/Guardian	Signature of Father/Guardian	Date

For staff use only: Reviewed by:_____ (initials) Follow up required: Y N Follow up completed:_____ (sign & date)