APPLICATION FOR HEALTHY STUDENT PROGRAM MEMBERSHIP 2021-2022

Student Name _____ **Sex** _____ **Grade** _____**DOB** _____
(Last, First, MI)

Student # _____ **Home Address** _____ **Home Phone** _____

PERSON TO BE CONTACTED IN CASE OF EMERGENCY:

Parent Name	**Place of Business**	**Business Phone**	
Backup Person to be Called		**Home Phone #**	**Cell Phone #**

STUDENT MEDICAL HISTORY

List any ALLERGIES to Medications or Food: _____

List any SURGERY/HOSPITALIZATION: _____

_____

List any CURRENT MEDICATIONS: _____

List any MEDICAL / HEALTH PROBLEMS: _____

_____

_____

FAMILY MEDICAL HISTORY: (Circle all that apply and indicate which family members have or have had the condition)

High Blood Pressure _____ **Tuberculosis** _____ **Diabetes** _____
Epilepsy _____ **Sickle Cell** _____ **Cancer** _____
Heart Problems _____ **Asthma** _____ **Arthritis** _____

Name of Family Physician _____ **Phone** _____

Name of Family Dentist _____**Phone** _____

Date of Student's Last Physical Exam _____ **Last Dental Exam** _____

ENROLLMENT STATEMENT

We agree to enroll _____ **in the Healthy Student Program. We understand that the program offers a limited range of HEALTH COUNSELING services on an as-needed basis. We further understand that these services DO NOT REPLACE the services of our family doctor. In case of accident or serious illness, the school policies outlined on the School's Emergency Information Card will be observed. We further understand that student information is confidential except in those instances when professionals are required by law to report child abuse, death threats, suicide risk, and public health concerns**.

Parent/Guardian Signature _____ **Date** _____