

Hawthorn District 73 Health Information – 2009/2010

Office

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Student Information

Last: _____ Legal First Name: _____ Middle Name: _____ Gender: _____ Grade (Fall): _____
Preferred Name: _____ Birthdate: _____ Birthplace (City, State or City, Country): _____
Is student covered by medical insurance? Yes No What is your child's Medicaid number (if any)? _____

Family Information

Home Address: _____ City: _____ ZIP: _____
Home Phone*: _____ Primary language spoken at home (if not English): _____
Is this student the youngest or only child in your family attending Hawthorn for the 2009/2010 school year?: Yes No

Parent/Guardian Contact Information

(Please list adults who live with this child.)

Home Phone

Work Phone*

Cell Phone*

Mother/Guardian Name: _____

Father/Guardian Name: _____

Are there Legal/Custodial Restrictions? Yes No

If Yes, please attach written documentation.

*Student Home Phone number and parent Work and Cell Phone numbers will be entered into our Emergency Phone Notification System. See www.hawthorn73.org/notify for info.

Emergency Contact Information

Please list two neighbors or nearby relatives who can pick up your child from school and assume temporary care if you cannot be reached during school hours.

(Other than parents)

Home Phone

Work Phone

Cell Phone

Contact 1 Name: _____

Relationship to Student: _____

Contact 2 Name: _____

Relationship to Student: _____

Health Information (If you need additional space, please use back of this page and make a note below.)

Important! Signature mandatory! This information will accompany your child to the hospital if emergency treatment is needed!

Chronic health conditions (such as asthma, ADD/ADHD, eye/vision or ear/hearing problems, heart problems, seizures, migraines, allergies/reactions—severe, food, seasonal):

Allergic to medications: _____

Surgeries, injuries, or hospitalizations (include dates): _____

Regular medication: _____ to be taken at home (times): _____

Regular medication: _____ to be taken at school (times): _____

Limitations in physical activity (PE, recess, team sports): _____

Doctor's Name: _____ Address: _____ Phone: () _____

Parent/Guardian Signature

By signing this form, I authorize emergency treatment and if necessary, permission for my child to be transported to the nearest hospital or doctor. I agree to pay all fees in connection with such treatment or service not covered by insurance. I authorize school personnel to contact persons directly named above if parents/guardians are not reachable. I understand that the information provided above will only be available to Hawthorn staff, or other authorized adults, who are directly involved with this child.

Signed: _____ Date: _____