

NO ACCESS

If there is a person who may **NOT HAVE ACCESS** to child, please indicate:
Please submit a copy of the order of protection to your child's school.

| Name | Relationship | Order of Protection Exists? | Effective Date of Court Order |
|------|--------------|--|-------------------------------|
| | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |

HEALTH INFORMATION

Name of Physician/Clinic: _____ Telephone _____

- Allergist/Immunologist Cardiologist Dermatologist Development/Behavioral Specialist
 Neurologist Pulmonologist Other _____

Health Alert

Does child have any health condition that may affect participation in physical activities? Yes No

Limitations _____
(e.g., stair climbing, participation in gym)

Known Diagnoses (please check all that apply)

- Asthma Seizures Allergies/Anaphylaxis Diabetes None Other _____

Allergies (select all that apply)

- Milk Eggs Peanuts Tree Nuts (Other Nuts) Fish
 Shellfish Soy Wheat Other _____

My child has (X any that apply): Private health insurance Medicaid No health insurance

If "No Health Insurance," are you willing to share contact information from this card to learn about insurance options? Yes No

It is understood that in the final disposition of an emergency case, the judgment of the school authorities will prevail.
The recommendation of the parent as indicated above will be respected as far as possible.

SIBLINGS

| Sibling's Last Name | Sibling's First Name | Sibling's School of Attendance |
|---------------------|----------------------|--------------------------------|
| | | |
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| | | |

SIGNATURE OF PARENT/GUARDIAN

- By checking this box, I agree to be contacted by elected School, District, and/or City-wide parent leader volunteers regarding events, updates, and other matters connected to my school community.
- By checking this box, I agree that my contact information can be shared with elected School, District, and/or City-wide parent leader volunteers so I can be updated on events and other matters connected to my school community.

Principal will be notified in writing of any changes to information on this card _____
Signature of Parent/Guardian

FOR OFFICE USE ONLY

To be completed by school staff only.

Grade _____ Class _____ Room No. _____ Teacher _____

List below contacts made for emergency, illness or injury. Relevant records from Health Record _____

| Date | Contact | Reason | Disposition |
|------|---------|--------|-------------|
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