2017-18 KEHILLAH HIGH

Health History

*All information is confidential.*

* Student's Name **\***First Last
* Student's Birthdate **\***MM/DD/YYYYPick a date.
* Does your child have any special learning needs or learn best in any specific types of educational settings? If yes, please describe



* Does your child have any special behavioral or emotional issues we can help support? If yes, please describe.



* Does your child have an IEP? If yes, please describe.



* Does your child have any other special issues or needs? If yes, please describe



HEALTH HISTORY

* Allergies (food, medicines, etc.) **\***

NoYes

* Anaphylactic allergies **\***

NoYes

* Asthma **\***

NoYes

* Diabetes **\***

NoYes

* Epilepsy/Seizures **\***

NoYes

* Hearing Problems **\***

NoYes

* Vision Problems **\***

NoYes

* If you answered YES to any of the above, please explain and list what accommodations we should consider.



* Does the student take medication of any kind? If YES, please give the name of the medication and its purpose.



* Are there any other issues that are life threatening, require medication, or should be brought to our attention?



EMERGENCY CONTACTS AND INSURANCE INFORMATION

Please provide us with the names of two people, other than yourself, who will be available to care for your child in case of an emergency.

* Emergency Contact #1 **\***FirstLast
* Relationship to Student **\***



* Phone Number **\***###-###-####
* Phone Number###-###-####
* Doctor's Name **\***



* Doctor's Phone Number **\***###-###-####
* Preferred Hospital **\***



* Dentist's Name **\***FirstLast
* Dentist's Phone Number **\***###-###-####
* Insurance Company **\***



* Group Number **\***



* Policy Number **\***



* Name of Insured **\***

