



## 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

## 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