NECHES
INDEPENDENT SCHOOL DISTRICT

2024–2025

Student's Name: _____ DOB: _____ Grade: _____

NISD Health Form

DOES THE STUDENT HAVE A HISTORY OF:

YES	NO	Please (✓) applicable answer
☐	☐	Asthma requiring medication
☐	☐	Heart Problems
☐	☐	Seizure Disorder
☐	☐	Migraine Headaches
☐	☐	Kidney/Bladder Problems
☐	☐	Bone/Joint Muscle Problems
☐	☐	Bleeding Disorder
☐	☐	Stomach/Ulcer Problems
☐	☐	Depression requiring medication
☐	☐	ADD/ADHD
☐	☐	Autism
☐	☐	Anxiety/Disorder requiring medication
☐	☐	ANY Other:

If Yes, explain:

_____

_____

_____

_____

_____

Allergy Information

Medical Alert Information

Check (✓) All that Apply.

☐ Bee Sting

☐ Food (Please Specify)_____

☐ Medicine (Please Specify)_____

☐ Pollen, Rag Weed

☐ Herbicide/ Pesticides

Are These Allergies Life Threatening?

☐ YES ☐ NO

If Yes, specify action for treatment.

_____

_____

_____

_____

Does the student wear glasses or contacts? _____

Does the student have any hearing problems? ☐ Tubes in ears? ☐

Date of Last Doctor visit: _____ Date of Last Dental visit: _____

Date of Chicken Pox illness: _____

I authorize this information to be released to Teachers and other pertinent personnel.

_____ _____

Parent or Guardian Signature Date

_____ _____

Phone Number E-mail

In case of injury or accident, I authorize medical treatment by a medical doctor in the event that I can not be reached.

-----Over-----

Emergency Contact and Medical Information

_____ _____ M F
Child's Name Date of Birth Sex

_____ _____
Parent's/Guardian's Name Parent's/Guardian's Name

_____ _____ _____ _____ _____
Home/Cell Phone Work Phone Home/Cell Phone Work Phone

_____ _____
Address Address

_____ _____
City, St Zip City, St Zip

_____ _____
E-mail E-mail

Alternative Emergency Contacts

_____ _____
Primary Emergency Contact Secondary Emergency Contact

_____ _____ _____ _____
Home/Cell Phone Work Phone Home/Cell Phone Work Phone

_____ _____
Address Address

_____ _____
City, St Zip City, St Zip

Medical Information

Hospital/Clinic Preference

_____ _____
Physician's Name Phone Number

_____ _____
Insurance Policy Number

Please list any medications, herbals, dietary supplements or over the counter medications your child currently uses or intermittently takes at home or at school: _____
_____

Please describe any serious reaction(s) that can result from either administering or withholding medications: _____
_____