

# Thetford Academy/Health Card

Student Name \_\_\_\_\_ DOB \_\_\_\_\_ Grade \_\_\_\_\_ Gender \_\_\_\_\_

**Parent/Guardian Name:** \_\_\_\_\_

Phone Numbers \_\_\_\_\_ Cell \_\_\_\_\_ Home \_\_\_\_\_ Work \_\_\_\_\_

Email address \_\_\_\_\_

**Parent/Guardian Name:** \_\_\_\_\_

Phone Numbers \_\_\_\_\_ Cell \_\_\_\_\_ Home \_\_\_\_\_ Work \_\_\_\_\_

Email address \_\_\_\_\_

**Physical Address (where student lives)** \_\_\_\_\_

**Emergency Contact** \_\_\_\_\_ **Relationship** \_\_\_\_\_

Emergency Contact Numbers \_\_\_\_\_ Cell \_\_\_\_\_ Home \_\_\_\_\_ Work \_\_\_\_\_

Email Address \_\_\_\_\_

**Emergency Contact** \_\_\_\_\_ **Relationship** \_\_\_\_\_

Emergency Contact Numbers \_\_\_\_\_ Cell \_\_\_\_\_ Home \_\_\_\_\_ Work \_\_\_\_\_

Email Address \_\_\_\_\_

**Health Insurance Provider** \_\_\_\_\_ **Health Insurance ID** \_\_\_\_\_

**Dental Insurance** \_\_\_\_\_ **Dental Insurance ID** \_\_\_\_\_

## Medical Contacts:

**Doctor Name** \_\_\_\_\_ **Doctor Phone** \_\_\_\_\_

**Dentist Name** \_\_\_\_\_ **Dentist Phone** \_\_\_\_\_

**Student Medical Information**

**Permission to Administer**      **Tylenol**      **Advil**      **Antihistamines**      **Tums**      **Cough Drops**  
Yes/No      Yes/No      Yes/No      Yes/No      Yes/No      Yes/No

**Conditions & Medications**

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**Asthma** Yes/No      **Asthma Meds** \_\_\_\_\_

**Dietary Restrictions** \_\_\_\_\_

**Diabetes** Yes/No      **Diabetes Meds** \_\_\_\_\_

**Seizures** Yes/No      **Seizures Meds** \_\_\_\_\_

**Other Medical Issues** Yes/No  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Other Meds** \_\_\_\_\_

**Allergies**

**EPI Pen Required** Yes/No

**Seasonal Allergies** Yes/No

**Food Allergies** Yes/No

**Insect Allergies** Yes/No

**Other Allergies** \_\_\_\_\_

I give permission for my student's doctor, dentist and the school nurse to share appropriate health information about my student. In case of serious accident or illness, the school will seek emergency advice and care, including transportation to the emergency room. I authorize the physician to administer emergency treatment. Every effort will be made to contact the family

\_\_\_\_\_  
**Parent/Guardian Signature**

\_\_\_\_\_  
**Date**