APPLICATION FOR HEALTHY STUDENT PROGRAM MEMBERSHIP 2015 - 2016

Student Name _____ Sex _____ Grade _____DOB _____
(Last, First, MI)
Student # : _____ Home Address _____ Home Phone _____

PERSON TO BE CONTACTED IN CASE OF EMERGENCY:

Parent Name	**Place of Business**	**Business Phone**	
Backup Person to be Called		**Home Phone #**	**Cell Phone #**

STUDENT MEDICAL HISTORY

List any ALLERGIES to Medications or Food: _____

List any SURGERY/HOSPITALIZATION student has had: _____

_____

List any CURRENT MEDICATIONS: _____

List any MEDICAL / HEALTH PROBLEMS that the student has: _____

_____

_____

FAMILY MEDICAL HISTORY: (Circle all that apply and indicate which family members have or have had the condition)

High Blood Pressure _____ Tuberculosis _____ Diabetes _____
Epilepsy _____ Sickle Cell _____ Cancer _____
Heart Problems _____ Asthma _____ Arthritis _____

Name of Family Physician _____ Phone _____

Name of Family Dentist _____Phone _____

Date of Student's Last Physical Exam _____ Dental Exam _____

Is student Medicaid eligible? YES _____ NO _____ Medicaid # _____

Medicaid insurance Plan _____

ENROLLMENT STATEMENT

We agree to enroll _____ in the Healthy Student Program. We understand that the program offers a limited range of HEALTH COUNSELING services on an as-needed basis. We further understand that these services DO NOT REPLACE the services of our family doctor. In case of accident or serious illness, the school policies outlined on the School's Emergency Information Card will be observed. We further understand that student information is confidential except in those instances when professionals are required by law to report Child Abuse, Death Threats, Suicide Risk, and public health concerns.

Parent/Guardian Signature _____ Date _____