APPLICATION FOR HEALTHY STUDENT PROGRAM MEMBERSHIP 2014 - 2015

Student Name	Sex _	Grade	DOB
(Last, First, MI) Student # : Home Address			
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			
CURRENTLY, DOES THIS STUDENT HAVE ANY MEDICAL / HEALTH PROBLEMS THAT WE SHOULD BE AWARE OF?			
Family Medical History: (Circle all that apply and indicate which family members have or have had the condition)			
High Blood Pressure	Tuberculosis	Diabetes	
Heart Problems	Sickle Cell Asthma	Cancer _ 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			
basis. We further understand the case of accident or serious illness Card will be observed. We furth instances when professionals are public health concerns.	iners a limited range of HEALTH CO at these services DO NOT REPLAC as, the school policies outlined on er understand that student inform e required by law to report Child Ab	E the services of the School's En nation is confide ouse, Death Threa	f our family doctor. In nergency Information ntial except in those ats, Suicide Risk, and
Parent/Guardian Signature		Date	