Teacher:	
Room Number:	 _
Grade:	
Diethdotor	

MAD RIVER LOCAL SCHOOLS STUDENT HEALTH CLINIC INFORMATION

STUDENT HEALTH CLINIC INFORMATION Birthdate:							
Stude	nt's Last	Name	First Name	Parents Na	mes	Work Pl	hone Numbers
Home	Phone N	Number:					
	rized Pio	ck up (N	Name and Phone Number)			 	
1. 2.							
Medic	al Condi	itions (su	ch as asthma, epilepsy, hea	art conditions e	tc.):		
Allowa	•••• (a a)	h aa h aa .	otings food stol				
Allerg	gies (suci	n as bee s	stings, food, etc):				
Takin	g Medica	ation (wh	nat kind):				
I und	erstand t	hat medi	cal information will be sha	red with staff a	s necessary for my ch	nild's health an	d safety.
Paren	t Signatu	ıre			Date		
			(F h-	1	1221		
			(FORM DE	elow for use in c	nnic omy)		
Staff	Signatur	· e	Title Ini	tials Sta	ff Signature	Title	Initials
Starr Signature True Ini							
*Care	given by Time	y staff na	med above		T		Parent
Date	In/Out	Initial	Reason for clini	c visit	Care g	given	Notified

STUDENT'S LAST NAME
(Please print in LARGE letters)

STUDENT NAME:	

Date	Time In/ Out	Initial	Reason for Visit	Care Given	Parent Notified