

**BBMCS STUDENT EMERGENCY & HEALTH INFORMATION**

**This is Confidential Information**

A Copy of Immunization Shot \_\_\_\_\_

Ethnicity \_\_\_\_\_

Grade/Room \_\_\_\_\_

\_\_\_\_\_  
Name of Child: (Last) (First) (Middle) Sex Date of Birth

\_\_\_\_\_  
House Number Street/ Village or P.O. Box Home Phone

\_\_\_\_\_  
Father or Guardian's Name Mother or Guardian's Name

\_\_\_\_\_  
Place of Work Place of Work

\_\_\_\_\_  
Father's Work Phone Mother's Work Phone

Please list the names of any relatives, friends or neighbors that we could phone to pick up your child in the event we are unable to contact you at the above numbers.

	Name	Address	Phone NO.
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
	NAME OF THE FAMILY DOCTOR	CLINIC CARE RECEIVED	PHONE Health INSURANCE

**PREVIOUS MEDICAL HISTORY**

To be completed by parent or guardian to assist us in more effectively meeting the needs of your child in the school situation.

YES	NO	
_____	_____	Allergies: Food _____ Drug _____
_____	_____	Other _____ (Pls. Specify) _____
_____	_____	Asthma: On Medication _____
_____	_____	Attention Deficit Hyperactive Disorder _____
_____	_____	On Medication: _____
_____	_____	Diabetes Mellitus or Insipidus _____
_____	_____	Epilepsy (Seizure Disorder) _____
_____	_____	Hearing Problem _____
_____	_____	Heart Problem: Specify _____
_____	_____	Rheumatic Fever _____
_____	_____	Vision Problems: Glasses _____ Contacts _____
_____	_____	Other : _____

My child is able to participate in a regular physical education class.

YES \_\_\_\_\_ NO \_\_\_\_\_ I give permission for the local ambulance to transport

My child to \_\_\_\_\_ in case of emergency.

Name of Hospital / Clinic

\_\_\_\_\_  
DATE

\_\_\_\_\_  
Signature of Parent / Guardian