

**Humboldt County School District
Emergency Health Form 2015-2016
_____ School**

Last Name First Name Gender Grade Birth Date

Student Lives With Phone

Does your Medical Insurance cover immunizations for your child? Yes No
Please check if applies to your child Medicaid NV Check-Up

Health Problems: Circle if child has *history of or is currently having health problem* and then explain symptoms, medications, etc. below. **If your child has NO known health problems please circle Z.**

A. Asthma	N. Neurological or Muscular Disease
B. Blood Disorder	O. Orthopedic Problem
C. Allergy to	P. Potentially Severe Allergic Reaction
D. Diabetes	R. Hearing Impairment
E. Seizures	S. Speech Impairment
F. Psychological	T. Heart Problem
G. Glasses	U. Other
H. PE Restrictions	V. Visual Impairment
I. Behavioral Management	W. Malignancy
L. Medical Devices	X. Pulmonary Disease
M. Genetic Disorder	Z. NO KNOWN HEALTH PROBLEMS

FOOD ALLERGIES MUST HAVE A WRITTEN STATEMENT FROM STUDENT'S DOCTOR

SIGNATURE _____ **DATE** _____