DUBLIN UNIFIED SCHOOL DISTRICT

Student Health Information

School Year: _____

Student's Name:		**Grade:** **Teacher:**	**Birthdate:** **Student ID:**
Parent/Guardian: 1	**Cell Phone:**	**Work Phone:**	**Home Phone:**
Parent/Guardian: 2	**Cell Phone:**	**Work Phone:**	**Home Phone:**
Emergency Contact: 3	**Cell Phone:**	**Work Phone:**	**Home Phone:**
Emergency Contact: 4	**Cell Phone:**	**Emergency Contact: 5**	**Cell Phone:**
Physician's Name:	**Phone Number:**	**Dentist's Name:**	**Phone number:**
Hospital:	**Insurance Carrier:**	**Policy ID:**	**Last Weight:**

Medical Alert: The school must be aware of any health problems or conditions (i.e. allergies, asthma, diabetes, seizures, recent surgeries, heart conditions, etc.) which may impact your child's health and safety at school.

Health Conditions:

Medication at school:

☐ My child does **not** need medication at school

Medication at home:

Allergies:

☐ No known allergies

I give my permission to DUSD to inform school staff of my child's health condition/problem: ☐ Yes ☐ No

Emergencies: In the event I cannot be reached, I hereby authorize Dublin Unified School District to arrange for named doctors or dentist, ambulance or hospital facility to provide treatment to my child in case of emergency, accident or illness.

Parent/Guardian Signature & Date	**Parent/Guardian Signature & Date**