Mansfield Independent School District
Student Health Services
Health Information

School _____ **Grade** _____ **Teacher**_____
Student Legal Name _____**DOB**_____**Student ID#** _____
Address _____ **City** _____,Tx. **Zip** _____

Parent/Guardian _____ Relationship to Student _____
Phone # (1) _____ (2) _____ E-mail _____
Parent/Guardian _____ Relationship to Student _____
Phone # (1) _____ (2) _____ E-mail _____
Alternate contacts to call in case of an emergency and parents/guardians cannot be reached:
Name _____ Relationship _____ Phone #_____
Name _____ Relationship _____ Phone #_____
Name _____ Relationship _____ Phone # _____

Physician Name _____ Phone # _____
Preferred Hospital _____ Phone # _____
Insurance: ☐ None ☐ Medicaid ☐ Texcare ☐ CHIP ☐ Other _____

Please check, if condition has been diagnosed by a doctor:

☐ ADD/ADHD	☐ Diabetes	☐ Migraine Headaches
☐ Allergy: Food**	☐ Down Syndrome	☐ Muscular/Orthopedic Disorder
☐ Allergy: Medication	☐ Ear Infections	☐ Psychiatric/Psychological Disorder
☐ Allergy: Seasonal	☐ Eating Disorder	☐ Serious Injury/Accident
☐ Asthma	☐ Epilepsy/Seizures	☐ Special Needs
☐ Blood Disorder	☐ Hearing Condition	☐ Vision Concerns
☐ Cerebral Palsy	☐ Heart Condition	☐ Wears Corrective Lenses
☐ Chicken Pox (date of disease ___/___/_____)	☐ Kidney Disorder	☐ Other _____
☐ Cystic Fibrosis Mth Day Year	☐ Meningitis	☐ Other _____

Explain any condition checked above: _____
_____

****** Parent must provide Student Nutrition office with a note from the doctor for any special considerations regarding school lunches.

Past injuries/illnesses/hospitalizations/surgeries: _____
_____

Please list all medications your child is currently taking:
Medication Name _____ Dose _____ Reason_____
Medication Name _____ Dose _____ Reason_____
Medication Name_____ Dose_____ Reason_____

It may be necessary for school personnel to apply topical first aid medications such as: anti-itch cream, tooth pain gel, saline eye drops. ☐ Yes, I give permission for my child to have topical OTC medications except the ones listed above that they have had a previous allergic reaction to. ☐ No, do not apply any topical OTC medications.

I, the undersigned, do hereby authorize officials of the Mansfield Independent School District to contact alternative adults and physicians listed. I authorize the school nurse, or trained personnel, to render treatment deemed necessary in case of an emergency. I authorize medical information to be shared with appropriate personnel. I will not hold Mansfield ISD financially responsible for the emergency care and/or transportation of said child.

_____ _____
SIGNATURE OF PARENT/GUARDIAN **DATE**