

STUDENT HEALTH HISTORY PERMISSION TO TREAT

Student's Full Name _____

Male _____ Female _____ Present Grade _____ Date of Birth _____

Present Address _____

Home Phone _____

My child has the following diagnosed medical condition(s): _____

My child takes the following medications (prescription or not) on a regular basis: _____

My child has the following known allergies: _____

Please provide the following information about your family's Health Care Insurance: _____

Company Name: _____

Policy Owner: _____

Policy Number: _____

Father's daytime phone: _____ Time at this number: _____

Father's night phone: _____

Mothers daytime phone: _____ Time at this number: _____

Mother's night phone: _____

If an emergency medical situation arises, and neither parent is available by phone, please provide a name and phone number of another contact person:

Name _____ Phone: _____

I authorize Dayton ISD personnel to seek emergency medical treatment for my child.

Signature

Date