# APPLICATION FOR HEALTHY STUDENT PROGRAM MEMBERSHIP 2021-2022

**Student Name** _____ **Sex** _____ **Grade** _____**DOB** _____
**(Last, First, MI)**

**Student #** _____ **Home Address** _____ **Home Phone** _____

PERSON TO BE CONTACTED IN CASE OF EMERGENCY:

| **Parent Name** | **Place of Business** | **Business Phone** | |
|---|---|---|---|
| **Backup Person to be Called** | | **Home Phone #** | **Cell Phone #** |

## STUDENT MEDICAL HISTORY

**List any ALLERGIES to Medications or Food:** _____

**List any SURGERY/HOSPITALIZATION:** _____

_____

**List any CURRENT MEDICATIONS:** _____

**List any MEDICAL / HEALTH PROBLEMS:** _____

_____

_____

**FAMILY MEDICAL HISTORY:** (Circle all that apply and indicate which family members have or have had the condition)

**High Blood Pressure** _____ **Tuberculosis** _____ **Diabetes** _____
**Epilepsy** _____ **Sickle Cell** _____ **Cancer** _____
**Heart Problems** _____ **Asthma** _____ **Arthritis** _____

**Name of Family Physician** _____ **Phone** _____

**Name of Family Dentist** _____**Phone** _____

**Date of Student's Last Physical Exam** _____ **Last Dental Exam** _____

## ENROLLMENT STATEMENT

**We agree to enroll** _____ **in the Healthy Student Program. We understand that the program offers a limited range of HEALTH COUNSELING services on an as-needed basis. We further understand that these services DO NOT REPLACE the services of our family doctor. In case of accident or serious illness, the school policies outlined on the School's Emergency Information Card will be observed. We further understand that student information is confidential except in those instances when professionals are required by law to report child abuse, death threats, suicide risk, and public health concerns**.

**Parent/Guardian Signature** _____ **Date** _____