NORTHERN TIOGA SCHOOL DISTRICT
STUDENT INFORMATION AND HEALTH HISTORY

STUDENT INFORMATION

Last Name ____________________________________
First Name ____________________________________
Middle Name ____________________________________
Resident Address ____________________________________
Apartment/P.O. Box ____________________________________
City ____________________________________
State __________ Zip Code _________________

Grade _______
Teacher ____________________
Gender (check one) ☐ Male ☐ Female

Phone Number_____________________________
Unlisted: ☐ Y ☐ N
Student Date of Birth____ / ____ / ____

With whom does the child reside?

Military Family Information: Is a parent/guardian an active military member? ____ Yes ____ No

PARENT/GUARDIAN INFORMATION

☐ Mother ☐ Father ☐ Guardian ☐ Step-parent ☐ Fosterparent ☐ Grandparent ☐ Other __________________

Last Name ____________________________________
First Name ____________________________________
Marital Status ☐ Married ☐ Unmarried ☐ Widowed
☐ Separated ☐ Divorced
(*) Address ____________________________________
City, State, Zip ____________________________________

Phone Number_____________________
Unlisted: ☐ Y ☐ N
Cell Number ________________________________
Employer ________________________________
Work Phone ________________________________

☐ Mother ☐ Father ☐ Guardian ☐ Step-parent ☐ Fosterparent ☐ Grandparent ☐ Other __________________

Last Name ____________________________________
First Name ____________________________________
Marital Status ☐ Married ☐ Unmarried ☐ Widowed
☐ Separated ☐ Divorced
(*) Address ____________________________________
City, State, Zip ____________________________________

Phone Number_____________________
Unlisted: ☐ Y ☐ N
Cell Number ________________________________
Employer ________________________________
Work Phone ________________________________

☐ Mother ☐ Father ☐ Guardian ☐ Step-parent ☐ Fosterparent ☐ Grandparent ☐ Other __________________

Last Name ____________________________________
First Name ____________________________________
Marital Status ☐ Married ☐ Unmarried ☐ Widowed
☐ Separated ☐ Divorced
(*) Address ____________________________________
City, State, Zip ____________________________________

Phone Number_____________________
Unlisted: ☐ Y ☐ N
Cell Number ________________________________
Employer ________________________________
Work Phone ________________________________

STUDENT MEDICAL INFORMATION

Family Doctor ____________________________________
Address ____________________________________

Hospital ________________________________
Preference ________________________________

Family Dentist ____________________________________
Address ____________________________________

TELEPHONE CALLING ORDER AND ANNUAL HEALTH UPDATE

During the course of the school year there are times when a student may need to leave school due to illness or communicable disease requiring transportation home. Parents or guardians may not be available during these times. Students who are ill must be dismissed to a responsible adult. Please list below the names of five (5) adults, including parents, who you would prefer for us to call in case of an illness or emergency. Please put these names in the order of who should be called first, second, etc. Please be sure to notify the school if a phone number changes.

Name	Relationship	Daytime / Cell Number
	Mother	
	Father	

HEALTH HISTORY

In order to help us plan for a safe and healthy school experience for your child, please check any of the following that currently apply to this student.

- ☐ ADD or ADHD Medication _____
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ History of Chicken Pox Disease Date of Chicken Pox Disease _____
- ☐ Depression
- ☐ Diabetes
- ☐ Eating Disorder, Anorexia, Bulimia, Obesity
- ☐ Seizure Disorder Medication _____
- ☐ Heart Condition Does it requireantibiotic prophylaxis? _____
- ☐ Life threatening Allergies (anaphylaxis) – Allergic to _____ Treatment _____
- ☐ Food or other allergies (non-life threatening) – Allergic to _____
- ☐ Medication during the school day (physician order required)
- ☐ Mental health concerns
- ☐ Hearing loss / wears hearing aid Y☐ N☐
- ☐ Wears corrective lenses (glasses or contacts) Distance☐ Near vision☐
- ☐ My child has special health care needs. Please have the school nurse contact me to develop a school based health plan.

The space below is provided for you to list any additional information regarding your child's health or medical conditions of which the school staff should be aware of.

I give permission to share this health information with school staff as needed. Y☐ N☐

Signature of Parent/Guardian: Date: