# SPENCERPORT CENTRAL SCHOOL DISTRICT

71 Lyell Avenue
Spencerport, NY 14559

## STUDENT HEALTH FORM

| Please make necessary changes in **RED** | Student's Legal Name (as appears on birth/adoption certificate) | Gender | DOB | Next School |
|---|---|---|---|---|
| | Current Address | Student Number | Next Grade | Phone Number |

Dear Parent/Guardian:

The purpose of this form is to update your child's school health record. This information is shared on a need-to-know basis with teachers and staff with your signed permission below. In updating this information, we can ensure your child's health in the school setting.

Occasionally, school health personnel will need to speak with your child's health care provider. To do this, we need your signed consent. On the back of this form is a HIPPA compliant consent form. Your signature provides us with your permission to collaborate with your health care providers.

We would appreciate your timely return of this form no later than the first day of school. If there are any questions, or if you need to speak to the school nurse personally, please call the school that your child will be attending.

## MEDICAL ALERT/HEALTH CONCERN

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## CURRENT MEDICATION

Home: ______________________________

School: ______________________________

*Emergency Medical Information:*
In case your child meets with a serious accident at school and we are unable to contact you, we have your permission to have your child transported to:

______________________________

Hospital | Student's Physician | Physician's Phone Number

Give permission for: ___Release to Emergency Contact ___ Transport to Hospital ___Sharing of Confidential Health Information

______________________________

Date | Signature of student (Over 18), Parent or Guardian | Relationship

*Our Mission is to educate and inspire each student to love learning, pursue excellence and use knowledge, skills and attitudes to contribute respectfully and confidently to an ever-changing global community.*

www.spencerportschools.org