Park Rapids Century
Health Information Sheet

Name of Studrent (Last, First Middle):	Grade:
Name of Parent or Guardian:	
Home/Cell Phone:	Work Phone:
Family Doctor:	Family Dentist:

Dear Parent/Guardian: Please fill this form completely since the birth of the child listed above.

Health History: Has the student had any of the following? If so, please state the year.

Allergy:	Mumps:
Chicken Pox:	Orthopedic:
Asthma:	Rheumatic Fever:
Emotional Disorder:	Strep Throat:
Measles/Rubeola:	Surgery (state kind):
Rubella:	
Other:	

Please state if this student is currently receiving medications of any kind:

_____

_____

Does this student require immediate care for bee stings? YES NO

For as long as the student is enrolled in Park Rapids Schools, may we have your permission to contact the following in case of emergency (if the parents/guardians cannot be reached by phone)? YES NO

Essentia Clinic _____ Sanford Clinic _____

Parent/Guardian Signature: Date: