

**STUDENT INFORMATION AND HEALTH FORM**

**ALL INFORMATION WILL BE TREATED WITH THE STRICTEST OF CONFIDENTIALITY.**

**STUDENT'S FULL LEGAL**

**NAME:** \_\_\_\_\_  
**STREET ADDRESS:** \_\_\_\_\_  
**CITY:** \_\_\_\_\_ **STATE:** \_\_\_\_\_ **ZIP:** \_\_\_\_\_  
**Date of Birth:** \_\_\_\_\_ **Age:** \_\_\_\_\_  
**Male:** \_\_\_\_\_ **Female:** \_\_\_\_\_  
**High School:** \_\_\_\_\_ **Grade:** \_\_\_\_\_  
**Guidance Counselor Name:** \_\_\_\_\_ **Phone Number:** \_\_\_\_\_

**PARENT/GUARDIAN (S) FULL LEGAL NAME:** \_\_\_\_\_  
**WORK PHONE:** \_\_\_\_\_ **CELL:** \_\_\_\_\_  
**HOME:** \_\_\_\_\_  
**Parents EMAIL:** \_\_\_\_\_ (further information will be email)  
**IN CASE OF EMERGENCY NOTIFY:** \_\_\_\_\_  
**PHONE:** \_\_\_\_\_

**Health Insurance Carrier:** \_\_\_\_\_  
**Policy Holder's Name:** \_\_\_\_\_

**Food and/or Drug Allergies:** \_\_\_\_\_

**IN CASE OF EMERGENCY, I HEREBY GIVE MY PERMISSION FOR MEDICAL TREATMENT TO BE GIVEN TO THE ABOVE NAMED CHILD.**

\_\_\_\_\_  
**Parent Signature** **Date**

**PLEASE PROVIDE A PHOTOCOPY OF THE ACTUAL HEALTH INSURANCE CARD AND COPY OF POLICYHOLDER IDENTIFICATION CARD.**