Covington Independent School District
Health & Medical Information

Student Name: _____ Grade:_____
Last First MI

School Year: _____ DOB: ____/____/____ Age_____
M D Y

Emergency Contacts:

_____
Name Relationship Phone Number

_____
Name Relationship Phone Number

If a parent/guardian cannot be reached please indicate an adult whom the school should call:

_____
Alternate Adult Relationship Phone Number

Physician: _____ Phone Number: _____
Dentist: _____ Phone Number: _____
Hospital : _____ Phone Number : _____

****Does the student take medication(s) on a regular basis?** Yes _____ NO _____
If **YES**, name of medication(s):

_____

_____

****Check those illnesses that this student has and/ or health condition(s) of which the school should be aware.**
Give dates, if possible, when illnesses/ diagnoses occurred.

_____ Asthma
_____ Diabetes
_____ Chicken Pox
_____ Epilepsy or Seizures
_____ Heart Condition
_____ Hepatitis
_____ Mumps
_____ Rheumatic Fever
_____ Vision Problems
_____ Wear Glasses
_____ Wear Contacts
_____ Hearing Problems
_____ Have Hearing Aides? (Left, Right, Bilateral)

Does this student have Allergic Reactions to any Drug, Insect Bites, or Foods? YES _____ NO _____
If **Yes**:

- Name of **Drug**, describe the type of reaction and treatment:
  _____
  _____
- Name of **Insects**, describe the type of reaction and treatment:
  _____
  _____
- *For **Food Allergies** please turn to the back of this page continued.*

The above information is true to the best of my knowledge and I, the undersigned, do herby authorize officials of this school to contact directly the people named on this form. And so authorize the named physician/ dentist to render such treatment as may be deemed necessary in an emergency for health of the named student. In the event physician, dentist, other persons named on this form, or parents/ guardians cannot be contacted, the school officials are hereby authorized to take whatever action is necessary in their judgment, for the health of the aforesaid student. I will not hold the school district financially responsible for the emergency care and/or transportation for said student.

_____
Signature of Parent/ Guardian Date

_____
Signature of Student Date