Dorado Academy
"An Advanced Learning Community"

ACADEMIC YEAR: 20__ - 20__

GRADE:

STUDENTS HEALTH RECORD

Student's name: _____

Birth date: _____ Blood Type: _____

Home address: _____

Father 's name: _____

Cell phone: _____ Work phone: _____

Mother's name: _____

Cell phone: _____ Work phone: _____

Emergency contact: _____ Phone: _____

KNOWN ALLERGIES

Is your child allergic to: ☐ Drugs ☐ Food ☐ Insects ☐ None

Other allergies (Please specify): _____ Does the child use an Epipen injector? ☐ No ☐ Yes

MEDICAL CONCERNS

Does the child have a diagnosed medical condition which requires care while he/she is at school?

☐ No ☐ Yes (Please specify): _____

☐ Hypoglycemia ☐ Heart Condition ☐ Diabetes ☐ Hemophilia

☐ Epilepsy ☐ ADD/ADHD ☐ Asthma ☐ Other: _____

Is the child currently taking medications? ☐ No ☐ Yes Is the P-VAC-3 document updated? ☐ No ☐ Yes

I authorize staff in Dorado Academy who are trained in the basics of first aid to give my child first aid when appropriate.

I understand that, in the event of an emergency requiring medical attention for my child, every effort will be made to contact me. If I cannot be reached or when the delay might endanger my child's health, I hereby authorize Dorado Academy to transport my child to the nearest medical facility and/or hospital.

I authorize the School Counselors to assist my child if necessary during the school year.

I authorize the School Nurse to give only prescribed medication or asthma therapy when necessary.

Parent's Name: _____

Parent's Signature: _____ Date: _____