

IGNITE ENTREPRENEURSHIP ACADEMY

STUDENT HEALTH INFORMATION

Student's Name	BirthDate		Date	Gender	
Address	City			Grade	
HomePhone	Cell Phone				
Parent/Guardian:	Parent/Guardian email:				
Student lives with:	_both parents	Mother	Father	Other	
MEDICAL HISTORY					
Family					
Doctor	Phone				
Current Medical Diagnosis (if					
any)					
YES/NO HAS YOUR CHILD EVE	ER HAD (if yes, pl	lease describe)			
Any Serious Allergies?	Yes or No		Please speci serious?	fy to what and how	
Asthma or Breathing Problems	Asthma or Bre	eathing Problems	How serious	?	
Orthopedic or Bone Problems?					
Heart Disease or Murmur?					
Kidney Disease?					
Seizures (type and frequency)?					
Diabetes (Insulin dependant? On ar insulin pump?)	1				

Name of Parent/Guardia PLEASE NOTE: The information requeste	Date	
With parent permission, 7-12 grade stu prescription, over-the- counter medical	dents may now carry and administer on ion.	e dose of easily identified non-
MEDICATION with the exception of and parent authorization.		sulin with proper signed prescriber
office.	DICTIC DDIIC EDEE DALIGV PAR	V / CTUDENTS TO CARRY AND
•	pinephrine injectors, and insulin).	
	norization form must be completed be can be given. This includes all OTC	
below) No If yes, what type(s) and reason:	
•	nedication that may need to be adminis	tered during school? Yes***(See
Has your child had the Chickenpox disease?		
Serious or Chronic Disease (i.e. Leukemia, transplant)?		
Outer?		
Other?		
Serious Accident/Injury?		

PLEASE NOTE: The information requested is considered to be essential for planning a program each year that will meet the needs of your child. This information will be kept confidential and only persons working directly with your student (i.e. teachers, administrators, nurse) will have access to this information.