THE SCHOOL BOARD OF BREVARD COUNTY, FLORIDA
HEALTH CARD

NAME _____ DOB _____ GRADE _____ SEX _____
LAST FIRST MI

ADDRESS _____ HOME PHONE _____
STREET CITY ZIP

FATHER _____ EMPLOYER _____ (W) PHONE _____ (C) PHONE _____

MOTHER _____ EMPLOYER _____ (W) PHONE _____ (C) PHONE _____

HEALTH CONDITIONS/ SPECIAL NEEDS – PLEASE CHECK

☐ ADD/ADHD
☐ Asthma
☐ Bleeding Disorder
☐ Cancer
☐ Cardiac Conditions
☐ Cystic Fibrosis
☐ Diabetes
☐ Epilepsy/Seizures
☐ Kidney Disorders
☐ Psychiatric Conditions
☐ Sickle Cell Disease
☐ Developmental Delay
☐ Surgery
☐ Other _____
☐ Other _____
☐ Other _____

ALLERGIES: ☐ Insect Bites ☐ Foods _____ ☐ Medicine _____

REACTION: _____

MEDICATION: Taken at: Home _____ School _____

IMMUNIZATION STATUS: ☐ Complete ☐ Incomplete

SPECIAL EQUIPMENT: ☐ Glasses ☐ Hearing Aid ☐ Wheelchair ☐ Braces ☐ Gastric Tube ☐ Tracheotomy ☐ Shunt ☐ Contacts

Do you authorize emergency medical treatment? ☐ **Yes** ☐ **No**

Student Physician Name: _____Phone: _____

Parent/Guardian Name *(Please print):* _____

Parent/guardian Signature: _____Date:_____

Revised January 2014