

**SCHOOL HEALTH RECORD  
MARIETTA CITY SCHOOLS  
([www.marietta-city.k12.ga.us](http://www.marietta-city.k12.ga.us))**

STUDENT NAME \_\_\_\_\_ NICKNAME \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ (m/f) \_\_\_\_\_ HOMEROOM \_\_\_\_\_

ADDRESS \_\_\_\_\_ HOME TELEPHONE \_\_\_\_\_

FATHER \_\_\_\_\_ MOTHER \_\_\_\_\_ GUARDIAN \_\_\_\_\_

EMPLOYER \_\_\_\_\_ EMPLOYER \_\_\_\_\_ EMPLOYER \_\_\_\_\_

Brothers/Sisters attending Marietta City Schools: Name \_\_\_\_\_ School \_\_\_\_\_ Name \_\_\_\_\_ School \_\_\_\_\_

Telephone Numbers: Telephone Numbers: Telephone Numbers:

Work \_\_\_\_\_ Work \_\_\_\_\_ Work \_\_\_\_\_

Cell Ph/Pager \_\_\_\_\_ Cell Ph/Pager \_\_\_\_\_ Cell Ph/Pager \_\_\_\_\_

**EMERGENCY CONTACT PERSONS: List names and telephone numbers of persons authorized to approve medical treatment and pick-up your child.**

NAME \_\_\_\_\_ RELATION: \_\_\_\_\_ TELEPHONE \_\_\_\_\_ (H) \_\_\_\_\_ (W) \_\_\_\_\_ (cellular)

NAME \_\_\_\_\_ RELATION: \_\_\_\_\_ TELEPHONE \_\_\_\_\_ (H) \_\_\_\_\_ (W) \_\_\_\_\_ (cellular)

**STUDENT PHYSICAL HISTORY (Check all that apply.)**

CORRECTIVE LENSES \_\_\_\_\_ ORTHOPEDIC PROBLEMS \_\_\_\_\_ SINUSITIS \_\_\_\_\_ ALLERGIES \_\_\_\_\_ SEIZURES \_\_\_\_\_ HEART ABNORMALITY \_\_\_\_\_

STOMACH DISORDER \_\_\_\_\_ SEVERE HEADACHES \_\_\_\_\_ BRONCHITIS \_\_\_\_\_ ASTHMA \_\_\_\_\_ DIABETES \_\_\_\_\_ KIDNEY DISORDER \_\_\_\_\_

CHICKEN POX \_\_\_\_\_ EAR INFECTIONS \_\_\_\_\_ PE LIMITATIONS \_\_\_\_\_ SURGERY(Type) \_\_\_\_\_

Explain any condition checked above. \_\_\_\_\_

Prescription Medicines routinely taken (Please list.) \_\_\_\_\_

**THE SCHOOL DOES NOT PROVIDE MEDICATION. A STUDENT MUST HAVE WRITTEN PERMISSION TO TAKE MEDICATION SENT FROM HOME.**

THE SCHOOL IS GIVEN PERMISSION TO COMPLETE ROUTINE HEARING, VISION AND DENTAL SCREENINGS FOR MY CHILD.

(In case of injury or serious illness, the school will contact the Parent or Guardian. If the school is unable to contact the Parent, Guardian or Emergency persons listed, the school will make the necessary arrangements for transportation and treatment. The Parent/Guardian will assume payment of fees.)

Signature of Parent or Guardian \_\_\_\_\_ Date \_\_\_\_\_ e-mail \_\_\_\_\_