STUDENT ATHLETE INFORMATION CARD

YOUR STUDENT

Student's Name ______________________ ______________________ ____
Last First MI

Home Phone ______________ Birthdate ______________ Sex ____ Grade ____

Street Address ____

City ______________________________________ Zip Code __________

PARENTS/GUARDIANS

1. Mr/Ms/Mrs ____

   Phone (H) ______________ (W) ______________ (Cell) ______________

   Other ______________________ Employer name ______________________

2. Mr/Ms/Mrs ____

   Phone (H) ______________ (W) ______________ (Cell) ______________

   Other ______________________ Employer name ______________________

THE MEDIA AT SCHOOL

In the course of school activities, FCPS staff and/or the news media occasionally wish to interview, photograph or videotape students, display their work or publish their names. Unless indicated otherwise below, we will assume permission to do so. (FCPS cannot control media coverage of events that are open to the public.) *Permission refused* __________

HEALTH AND EMERGENCY INFORMATION

HEALTH CARE CONTACTS

Health Care Provider/Physician ______________________ Phone ______________________

Dentist ______________________ Phone ______________________

Health Insurance Co. ______________________ Phone ______________________

STUDENTS' MEDICAL HISTORY (CHECK THOSE THAT APPLY):

____ ADHD
____ ADD
____ Allergy: Bee Sting
____ Allergy: Food
____ Allergy: Latex
____ Allergy: Medication
____ Allergy: Pesticide/Chemical*
____ Allergy: Seasonal
____ Anorexia/Bulimia
____ Asthma
____ Dental Problem
____ Diabetes
____ Disability – Physical
____ Earaches/Infections – Frequent
____ Eczema
____ Fainting Spells
____ Gastrointestinal Disorder
____ Headaches – Frequent
____ Hearing Problem/Wears Aids
____ Heart Condition
____ Kidney/Bladder Problems
____ Menstrual Problems
____ Orthopedic Condition
____ Seizure Disorder
____ Sore Throats – Frequent
____ Speech Problem
____ Stomachaches – Frequent
____ Vision Problem –
____ Wears Glasses/Contacts

If any of above was checked, please explain. Also include anything about child's health that will help staff better understand and work with him/her. ______________________

DOES YOUR CHILD NEED MEDICATION FOR ANY CONDITION?

At Home: Y / N At School: Y / N

Name of Medication: ______________________ Dosage: ______________________

Reason Needed: ______________________

Reminder: You must supply medication form completed by a health care provider for each medicine the student takes at school.