



**EPISCOPAL**  
HIGH SCHOOL  
of JACKSONVILLE

## HEALTH INFORMATION FORM

*Please note: medical information to be given to licensed medical personnel in event of an emergency.*

Student name \_\_\_\_\_ grade \_\_\_\_\_

Student's primary physician

Name: \_\_\_\_\_

**Parent one**

Phone: \_\_\_\_\_

Name: \_\_\_\_\_

Specialist: \_\_\_\_\_

Home phone: \_\_\_\_\_

Phone: \_\_\_\_\_

Work phone: \_\_\_\_\_

Cell phone: \_\_\_\_\_

**Insurance information**

Provider: \_\_\_\_\_

Policy number: \_\_\_\_\_

Group number: \_\_\_\_\_

**Parent two**

Name: \_\_\_\_\_

Home phone: \_\_\_\_\_

Work phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

**Prescription medication**

All prescription medication(s) needed at school should be delivered to the front office by a parent with written dispensing instructions. It is the student's responsibility to come to the office to take the prescribed medicine. **EXCEPTIONS:** Emergency medications (i.e., epi pens, inhalers, and insulin) may be kept in the students' possession after they register their medications with the attendance office.

**Emergency contact (other than parent)**

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Home phone: \_\_\_\_\_

Work phone: \_\_\_\_\_

**Episcopal clinic medication(s)**

\_\_\_\_\_  
\_\_\_\_\_

**Over-the-counter medications**

I authorize Episcopal High School to administer the following over-the-counter medications to my child as needed:

Yes\_\_ No\_\_ 2 acetaminophen pills (325mg)

Yes\_\_ (1\_\_ or 2 \_\_ pills) No\_\_ ibuprofen (200mg)

Yes\_\_ No\_\_ Pepto-Bismol (chewable)

Yes\_\_ No\_\_ Triple B antibiotic ointment

Yes\_\_ No\_\_ cough drops

**Medical condition(s): (allergies, asthma, diabetes, etc.):**

\_\_\_\_\_  
\_\_\_\_\_

**Disclosure of all medications:**

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_ I choose not to disclose. (Failure to disclose may hinder medical professionals' ability to treat your child in an emergency.)

**Signature of parent/guardian:**

X \_\_\_\_\_