



The Garden Road School

Health Form

PARENT SECTION

Student Name: _____

Gender: M / F Class: _____ DOB: _____

Please list any allergies:

Allergy:	Symptoms:	Action/medication necessary:
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_____	_____	_____
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_____	_____	_____
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_____	_____	_____
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Please list any other health problems and/or medications taken:

Parent Signature: _____ Date: _____

HEALTH PROVIDER SECTION

This child is in good health and is ready to attend school.

NOTE: Please attach immunization history.

Height: _____ Weight: _____

Body Mass Index: _____ BMI Percentile: _____

Vision: _____

Hearing: _____

Health Provider's signature: _____ Date: _____

Health Provider's Name: _____ Phone: _____

Health Provider's Address: _____