PANAMA LOWER ELEMENTARY SCHOOL

PLEASE FILL OUT ALL THE INFORMATION

DATE:____________________

STUDENT INFORMATION

Student Name:______________________________________ Grade:__________ Sex: M F
(Last) (First) (Middle) (Circle One)

Date of birth:__________ Age:_______ Place of birth:______________________________
(Month-Date-Year) (Town) (State)

Are you of Hispanic/Latino culture or orgin? (Yes or No)

What is your race?(Choose one or more)
A. American Indian or Alaskan Native
B. Asian
C. Black/African American
D. Native Hawaiian or Other Pacific Islander
E. White

SSN:______________________ Contact telephone:______________________

Mailing Address: P.O. Box #______________ Town and zip code: ______________________

Street address:______________________ Town and zip code:______________________

What bus number do you ride?______________________

PARENT/GUARDIAN INFORMATION

Parent/Guardian #1:____

Employer:______________________________________ Telephone:______________

E-Mail Address:____

Parent/Guardian #2:____

Employer:______________________________________ Telephone:______________

E-Mail Address:____

(SIBLING INFORMATION (LIST THE NAMES, AGES, & SCHOOL THEY ATTEND)

______________________________ ______________________________

______________________________ ______________________________

LIST TWO EMERGENCY NAMES AND TELEPHONE NUMBERS

Emergency Name #1:______________________________ Telephone:______________

Emergency Name #2:______________________________ Telephone:______________

The following has my permission to pick my child up from school:______________________

____

Parent signature:____

PANAMA PUBLIC SCHOOLS
STUDENT HEALTH SURVEY

PLEASE COMPLETE FRONT/BACK AND RETURN TO THE OFFICE.
IF THIS INFORMATION CHANGES AT ANY TIME DURING THE YEAR PLEASE CONTACT THE NURSE WITH THE NEW INFORMATION. THANK YOU.

STUDENT'S NAME: ______________________________

DATE OF BIRTH: SEX: GRADE: ______________________________

PARENT INFORMATION: ______________________________
(NAME) *(TELEPHONE NUMBER)*

PARENT INFORMATION: ______________________________
(NAME) *(TELEPHONE NUMBER)*

EMERGENCY CONTACT: ______________________________
(NAME) *(TELEPHONE NUMBER)*

EMERGENCY CONTACT: ______________________________
(NAME) *(TELEPHONE NUMBER)*

Please list below any Food or Drug allergies your child has.

____
____
____

Has your child ever had or has now? (Please check at right of each item.)

	YES	NO	YEAR		YES	NO	YEAR
High blood pressure				Excessive worry/anxiety			
Heart Condition				Depression			
Asthma				Ulcer			
Severe Allergies				Chronic Abdominal Pain			
Positive TB test				Excessive colds			
Tumor/growth/cancer				Speech Problems			
Diabetes				Eye Trouble			
Skin Disease				Frequent Ear Infections			
Concussion				Hearing Loss			
Frequent Headaches				Kidney Problems			
Dizziness/Fainting				Intestinal Trouble			
Severe head injury				Wets or Soils Pants			
Epilepsy (Convulsions)				Scoliosis in Family			
Orthopedic problems				Operations			
Attention Deficit Disorder				Bee sting sensitivity			

Does your child have any other health or behavior problems? Explain: ______________________________

____

Is your child under regular medical supervision for any of the above conditions? ______________________________

If yes, explain and list the name of the doctors with telephone numbers and any medications.

____
____
____

______________________________ Date ______________________________ Parent Signature