CONFIDENTIAL **CONFIDENTIAL**

Fort HealthCare
Student Health Emergency Information
(Information valid through August 15, 2026)

Child's Name	Date of Birth / Age	School / Grade (if applicable)

Parent/Guardian Name	Phone Number
Email Address	Home Address

Preferred Method of Communication: ☐ Text ☐ Call ☐ Email
Does your child currently receive speech/language services? ☐ Yes ☐ No
If so, where? (Ex: through a school district, private practice, etc.)_____

Please indicate area of concern: _____Speech articulation _____Language _____Social skills

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Medical History: (check all those that apply):

☐ Asthma
☐ Attention Deficit Disorder (ADD, ADHD)
☐ Diabetes
☐ Seizure/Epilepsy: Last Seizure _____
☐ Mental Health (please specify): _____
☐ Takes Prescription medication**: List:_____
☐ Other Health Conditions_____
☐ Surgery in last 12 months: List:_____

Does your child have severe or life threatening allergies? ☐ Yes ☐ No
(If yes, please check the appropriate box(s) and list what it is and the treatment for it)

☐ Insect (Bee/Insect):_____
☐ Food:_____
☐ Medication:_____
☐ Other:_____

*_**When a Medication for an allergic reaction is required it is the responsibility of the parent to provide the medication (antihistamine or EPI-PEN) and the completed Administration of Medication form prior to administration of the medication.**_

Notice: Fort HealthCare does not provide student accident insurance. Such insurance is the responsibility of the parent/guardian and/or student, as well as all medical/dental costs due to accidental injury. I hereby authorize school district employees to call for emergency assistance, which could require a doctor, dentist, and/or ambulance. The information on this form may be shared with appropriate school staff.

Parent/Guardian Signature _____ **Date**_____

Non-Employee Consent Form for Photography, Filming, Advertising and Other Marketing Related Uses

I give my consent to use my photo in videotapes, film, photographs, and recordings of me for broadcast, internet, social media, print publications, brochures, press releases, billboard, direct mail, and other uses by Fort HealthCare.

In giving this consent, I release Fort HealthCare, their agents and assigns from any liability for any violation of any personal or property rights which I might have in connection with such materials, and waive any right to approve accompanying written or narrative material.

I represent that I am of full legal age, or if under the age of 18, I have my parent/guardian approval.

Date of Photo/Film _____ Location _____

Photographer/Videographer _____

Interviewer _____

_____ _____

Name of Participant

Signature
(Parent/Guardian Sig. Required if under the age of 18)

_____ _____

Name of Parent/Guardian
(If under the age of 18)

Date

(_____)_____
Contact / Phone Number