

**Excelsior Classical Academy  
HEALTH SERVICES FORM 2022-23**

**Please fill out this entire form. This information will be kept confidential.**

**Student's Legal Name:**

Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_

Date of birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security Number \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Student's Address \_\_\_\_\_ Apt. \_\_\_\_\_ Zip Code \_\_\_\_\_

**Contact Person**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Relation \_\_\_\_\_

Address \_\_\_\_\_ Apt. \_\_\_\_\_ Zip Code \_\_\_\_\_

Does the student reside at this address? \_\_\_\_ (Y/N) Phone Numbers: Home \_\_\_\_\_

Cell \_\_\_\_\_ Work \_\_\_\_\_

**Contact Person**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Relation \_\_\_\_\_

Address \_\_\_\_\_ Apt. \_\_\_\_\_ Zip Code \_\_\_\_\_

Does the student reside at this address? \_\_\_\_ (Y/N) Phone Numbers: Home \_\_\_\_\_

Cell \_\_\_\_\_ Work \_\_\_\_\_

**Other Emergency Contact** \_\_\_\_\_ **Home phone** \_\_\_\_\_

**Work phone** \_\_\_\_\_ **Student's Doctor/Clinic** \_\_\_\_\_

**Doctor's phone** \_\_\_\_\_ **Clinic's phone** \_\_\_\_\_

**Special medical conditions/allergies/procedures of which the school should be aware:** \_\_\_\_\_

**Medicines taken regularly at home:** \_\_\_\_\_

**Medicines taken regularly at school:** \_\_\_\_\_

**Does the student have:**

Private Insurance \_\_\_\_ (Y/N)

Medicaid \_\_\_\_ (Y/N)

**Does the parent/guardian request insurance information?** \_\_\_\_ (Y/N)

**All of the information given on this form is correct.**

**PARENT/GUARDIAN SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

**STUDENT HEALTH SERVICES: I understand that Excelsior Classical Academy staff will provide school health services as outlined in the attached summary, and give permission for any Excelsior employee to provide the described services to the student as he/she may require while present in school. I understand that, if the student has a serious injury or illness, I will be contacted and the physician/clinic shown on this form and/or Emergency Medical Services (EMS) may be contacted if necessary. I understand and agree that neither Excelsior Classical Academy nor its staff will be responsible for any cost involved if the student needs emergency medical care. I understand and agree that, in order to provide a coordinated system of care, Excelsior employees may exchange health care information about the student with the student's physician or other health care providers, upon approval by me. I further understand that my signature approves an Excelsior employee to give permission for my child to be treated in the event that I am not able to be reached for approval.**

**PARENT/GUARDIAN SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_