

PLEASE COMPLETE BOTH SIDES OF THIS FORM

BROOME-TIOGA BOCES INSTRUCTIONAL PROGRAMS STUDENT INFORMATION - HEALTH DATA/PERMISSION

Please Complete, Sign, & Return this form to BOCES

School Year: **2023-2024** School District: _____ Bus#: _____

BOCES Site & Program: _____

Session: **AM PM ALL DAY** Teacher: _____ Team/Room: _____

Student: _____ M F
Last First Initial

Date of Birth: ____/____/____ Home Phone: _____

Home Address: _____
Street, City, State, & Zip

Parent/Guardian1 Name: _____

Employer: _____ / _____ Email: _____
Work Hours

Work Phone: _____ Cell Phone: _____

Parent/Guardian2 Name: _____

Employer: _____ / _____ Email: _____
Work Hours

Work Phone: _____ Cell Phone: _____

EMERGENCY/MEDICAL INFORMATION:

Doctor's Name: _____ Phone: _____

Home Health Care Company: _____ Phone: _____

Medicaid Service Coordination: **YES or NO** Agency: _____

Medicaid Service Coordinator: _____ Phone: _____

Current Medications:

Allergies: Identify the specific allergen (*peanuts, bees, etc.*) and explain Reaction & Treatment.

Allergen: _____ Reaction: _____ Treatment: _____

Allergen: _____ Reaction: _____ Treatment: _____

Allergen: _____ Reaction: _____ Treatment: _____

Allergen: _____ Reaction: _____ Treatment: _____

