

**Mason City Schools Health Services Information**  
**Student With Identified Health Problem**

Date Submitted: \_\_\_\_\_

Student Name: _____	Condition: _____
Mother's Name: _____	Phone #1: _____ Phone #2: _____
Father's Name: _____	Phone #1: _____ Phone #2: _____
Emergency Contact Name: _____	Phone #1: _____ Phone #2: _____

Symptoms:	Immediate Action:	Secondary Action:
1. _____	1. _____	1. _____
2. _____	2. _____	2. _____
3. _____	3. _____	3. _____
4. _____	4. _____	4. _____

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Clinic Notes: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_