STUDENT'S NAME: _____ **GRADE:** _____

MEDICAL INFORMATION:

Doctor's Name: _____ Phone: _____

Dentist's Name: _____ Phone: _____

Hospital Preferred: _____

****

Does your child have any allergies? (I.e. foods, medicines, bees, seasonal, etc.) YES NO
If "yes", please list:

Allergy _____ Reaction child has had: _____

Allergy _____ Reaction child has had: _____

Allergy _____ Reaction child has had: _____

Does your child require an Epi-Pen for emergency use due to an allergy? YES NO

Does your child have a history of any medical problems, hospitalizations, significant injuries or surgeries that should be brought to the attention of the school? (I.e. asthma, diabetes, etc.) YES NO

If "yes", please describe: _____

_____

_____

Does your child have any behavioral/mental health problems (i.e. ADD, ADHD, Autism etc.) that should be brought to the attention of the school? YES NO
If "yes", please describe: _____

_____

***** Attach any additional information that might be needed.**

Does your child take any medication regularly at home that should be brought to the attention of the school?
YES NO

If "yes", please list the medication(s) and reason taking (do not include vitamins):

Medication: _____ Reason: _____

Medication: _____ Reason: _____

Medication: _____ Reason: _____

STUDENT'S NAME: _____ **GRADE:** _____

MEDICAL INFORMATION:

Please put an "X" through the following topical over the counter medicines that you *DO NOT* want administered at the school as needed:

Triple Antibiotic Ointment: for wound care

1% Hydrocortisone Cream: skin irritations, rashes, incent bites

Hydrogen Peroxide: for wound cleansing irritations

Caladryl/Calamine Lotion: rashes due to poison or other

Tylenol: for headache

Ibuprofen: for headache, inflammation

Diocesan Policy for Medication Administration while in school requires completion of a "Medication Administration Form" by all parents/guardians (for over the counter meds.) and the parent plus the physician (for prescription meds). All prescription and over the counter medications that are to be given while at school requires the parent to bring the medicine to the school labeled properly according to policy (Student name, doctor name, medication and dosage if prescription).

School Based Health

In the interest of maintaining your child's fullest capacity to learn, the School Based Health Program will offer a variety of services and classroom education during the year. **Please "X" through services that you *DO NOT* wish your child to receive:**

Basic First Aid/Nursing Care

Vision Screening

Hearing Screening

Height, Weight, BMI Screening

Counseling and risk assessment (with parent's permission only)

IN THE EVENT THAT REASONABLE ATTEMPTS TO CONTACT ME OR THE ALTERNATE NAMED INDIVIDUALS PROVE UNSUCCESSFUL, I HEARBY GIVE MY CONCENT FOR THE ADMINISTRATION OF ANY TREATMENT DEEMED NECESSARY BY THE ABOVE NAMED PHYSICIAN OR DENTIST, OR IN THE EVENT DESIGNATED PREFERRED PRACTIOIONER IS NOT AVAILABLE, BY ANY OTHER LICENSED PHYSICIAN OR DENTIST.
THIS AUTHORIZATION DOES NOT COVER MAJOR SURGERY UNLESS THE MEDICAL OPINIONS OF TWO OTHER LICENSED PHYSICIANS OR DENTISTS CONCURRING IN THE NECESSARY FOR SUCH SURGERY ARE OBTAINED PRIOR TO THE PERFORMANCE OF SUCH SURGERY.

PARENT/GUARDIAN NAME (Print); _____

Phone: (specify home, cell, work):_____

PARENT/GUARDIAN NAME (Print); _____

Phone: (specify home, cell, work):_____

OTHER EMERGENY CONTACT: _____

Phone: (specify home, cell, work):_____

Signature of Parent/Guardian: _____