Angelo Catholic School

20__-20__ Emergency/Health History

Grade ____

______________________________ ______________________________

Student Last Name Student First Name

Birthdate ____________________ ( ) M ( ) F

Parent/Guardian Name ____

Home Number ____________________ Cell Numbers ______________________________

Home Address ____

Mother's Place of Employment ______________________________ Work Number ____________________

Father's Place of Employment ______________________________ Work Number ____________________

The individuals listed below have permission to pick up my child from school or may be called in case of an emergency.

1. ____ Phone Number____________________

2. ____ Phone Number____________________

3. ____ Phone Number____________________

In order to better serve your child's health needs, please check if any items listed below apply, and explain, if necessary.

( ) Allergy If so, to what?__________________________

Requires Medication? ( ) yes ( ) no

Name of medication_____________________

( ) Food Allergy If so, to what?__________________________

Special requirements?____________________

( ) Asthma If so, requires medication / inhaler? ( ) yes ( ) no

Name of medication____________________

How often?_______ Taken at school?______

( ) ADHD If so, requires medication?

Name of medication__________

( ) Diabetes If so, what type?_________ Medication ? ( ) yes ( ) no

Name of medication ___________________

( ) Ear Frequent infections? ( ) yes ( )no

Hearing loss? ( ) yes ( )no

( ) Seizure Requires Medication? ( ) yes ( ) no
Name of medication ________________

( ) Heart If so, requires medications? ( ) yes ( ) no
Name of medication_________________

( ) Orthopedic Explain____

( ) Vision Wears glasses? ( ) yes ( ) no
Contacts? ( ) yes ( ) no

( ) Others Explain____

Please list any other medications your child takes on a regular basis.

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Please list any other important health information ____

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Any student taking prescription medication from school personnel needs a "Medication Request" form completed annually per medication before the medicine can be given.
No over the counter medications (Tylenol, Motrin, etc.) are allowed to be given by the school unless accompanied by a doctor's prescription/note.

In the event I may not be able to be reached, I authorize the principal or other professional employee to consent to emergency medical treatment for my child's minor illness or injury. I also authorize emergency transportation of my child by available emergency medical services.

_____________________________________ _____________________________
Parent Signature Date