CONFIDENTIAL HEALTH INFORMATION

In case of an emergency, the school staff will contact 911.
Every attempt will be made to contact a parent, a guardian, or a designated emergency contact.

STUDENT INFORMATION

Last: First: Middle:	Date of Birth:	Gender ☐ M ☐ F	Grade

School Name: Saint John Regional Catholic School

Does the student have health insurance?
☐ Private ☐ Medical Assistance ☐ No Insurance

Does the student have dental insurance?
☐ Y ☐ N

CURRENT HEALTH CONCERNS

Please check the following health concerns that may impact the student's educational day. This information may be shared with SJRCS staff as appropriate.

☐ **The student does not have any medical concerns**

☐ ADD/ADHD

☐ allergies **(choose all that apply)**

- ☐ foods _____
- ☐ bee sting/insect bite _____
- ☐ medicines _____
- ☐ pesticides/chemicals
- ☐ _____ other

☐ asthma: Has the student experienced an asthma episode in the past 12 months? ☐ Yes ☐ No

☐ blood disorder _____

☐ cancer

☐ diabetes

☐ hearing problems ☐ hearing aid(s)

☐ heart problems _____

☐ mental health diagnosis_____

☐ physical disability _____

☐ seizures

☐ vision problems _____
☐ glasses ☐ contacts

☐ other _____

☐ **This information is a change in health condition from the last school year**

MEDICATIONS

List all medications and dosages your child receives on a routine basis

☐ **Medications are not required at school**

*If the student requires over-the-counter or prescription medications or treatments at school, the health care provider and parent **must** complete and submit the appropriate authorization form(s). Obtain forms from the SJRCS health room or at sjrcs.org (Click on Parents tab, then health forms).*

Medications: _____

_____

I hereby give authorization and consent to the school, in the event that I cannot be contacted, to obtain emergency medical care and necessary emergency transportation to a healthcare facility. I understand and authorize that my child's medical records or other medical information, furnished to the school, will be shared with SJRCS staff and emergency personnel who have a legitimate medical/ educational purpose for accessing such medical records and information.

Parent/Guardian name (please print):_____ Primary Contact Ph# _____

***Signature* of Parent / Guardian:_____ Date _____**

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