SACRED HEART OF JESUS SCHOOL
2017-2018 Health/Emergency/Student Information

Student's Name_____Grade & Class____ A or B (circle one)

Age ____Date of Birth _____ Male / Female (circle one)

Race: White / Black / Hispanic / Asian / American Indian / Multi (circle one)

Student's Social Security # _____ Catholic / Non-Catholic (circle one)

Church Parish _____ Civil Parish _____

Home Address _____

Home Phone _____ Student resides with _____

Mother's Name _____ Work Phone _____
Cellphone or Pager _____

Father's Name ____ _____ Work Phone _____
Cellphone or Pager_____

E-mail address_____

Other Emergency Contacts: (These people are allowed to pick up my child from school.)

Name	Relationship	Home Phone	Work Phone	Cell or Pager #

***Must have at least two additional contacts listed.**

My child MAY NOT leave school with _____

Name of student's doctor _____ Phone _____
Doctor's address_____

Parent's hospital preference _____
Health Insurance Plan (other than school insurance)_____
Policy holder's name _____ Policy #_____

I hereby authorize the emergency contacts named above to act on my behalf regarding the release of my child from school. I further authorize to act on my behalf regarding treatment of my child in the event of a medical emergency, which may endanger his/her life, cause physical disability, or cause undue discomfort if delayed. This authorization is granted only after a reasonable effort has been made to contact my child's parent or legal guardian. In addition, I authorize school personnel to release my child's medical information to emergency personnel.

Signed _____ Date _____
(Parent or Legal Guardian)

PLEASE COMPLETE HEALTH INFO ON BACK

1. Please check off if student has been diagnosed with any of the following:

___ ADD/ADHD (circle one)
___ Depression/Anxiety disorder (circle one)
___ Migraine headaches
___ Seizure disorder
___ Asthma
___ Bone/Joint Disorder
___ Diabetes/Low Blood Sugar (circle one)
___ Frequent nosebleeds
___ Scoliosis
___ Skin problems (excema, dermatitis, etc.)
___ Heart or blood condition
___ Tubes in ears
___ Hearing impairment
___ Eye problem (lazy eye, color blind, etc.)
___ Wears eyeglasses/contact lenses
___ Chronic stomach problems
___ Other (Please explain below)
___ NOTHING APPLIES

2. Please provide further explanation of any of the above if warranted.

_____.

3. Has your child had any surgeries? Please explain._____

_____.

4. Any serious allergic reactions that might require emergency care? _____

___ Ant bites ___ Bee stings ___ Latex ____ Medication ____ Foods (Which ones?)
___Pesticides (Which one?_____)

Nature of reaction and type of intervention needed:_____

_____.

5. Does your child take any daily or long-term medication? _____
Name of medication, dosage, and time given: _____

_____

6. Does your child have any physical limitations or chronic disabilities of which school personnel should be aware? Please explain. _____

_____.

7. Please add specific instructions or other information for special conditions your child has.

_____

_____

8. Has your child been fully immunized? If not, do you plan to complete immunizations?

_____