



**Sacred Heart of Jesus School**  
**2024/2025 Health/Emergency/Student Information**

**Please list all parents and/or guardians complete contact information. Two additional emergency contacts and their information are required.**

Student's Name		Grade		Age		Date Of Birth	
Catholic		Non-Catholic		Church Parish:		Civil Parish:	
Home Address				Home Phone			
Student resides with:		Both Parents		Mom		Dad	
Mother's Name		Cell ( ) --		Work ( ) --			
E-mail							
Dad's Name		Cell ( ) --		Work ( ) --			
E-mail							
Other/Guardian's Name		Cell ( ) --		Work ( ) --			
E-mail							
At least two other emergency contacts are required. These people are allowed to pick up my child from school.							
Name		Relationship		Home		Cell	
				( ) --		( ) --	
				( ) --		( ) --	
				( ) --		( ) --	
				( ) --		( ) --	
<b>My child may not leave school with</b>							
Student's Primary Care Physician's Name				Phone		( ) --	
Address:							
Hospital Preference							
Insurance Name:							
Policy Holder's Name				Policy Number			

**2024/2025 Health/Emergency/Student  
Information** This form must be updated every year.

<b>Significant Allergies That Might Require Emergency Care.</b>													
<b>Food Allergies</b> (An allergy packet must be completed including a physician statement each year or it will be listed as a food intolerance.)													
<input type="checkbox"/>	No Food Allergies	<input type="checkbox"/>	All Nuts	<input type="checkbox"/>	Tree Nuts	<input type="checkbox"/>	Peanuts	<input type="checkbox"/>	Dairy	<input type="checkbox"/>	Other		
<b>Environmental Allergies</b>													
<input type="checkbox"/>	No Environmental Allergies	<input type="checkbox"/>	Bees	<input type="checkbox"/>	Wasp	<input type="checkbox"/>	Ants	<input type="checkbox"/>	Latex	<input type="checkbox"/>	Grass	<input type="checkbox"/>	Other
<b>Medication Allergies</b>													
<input type="checkbox"/>	No Medication Allergies	<b>If Yes, please List:</b>											
<b>Does the student need an Epi-Pen at school for allergic reactions?</b>								<input type="checkbox"/>	No	<input type="checkbox"/>		Yes! Please fill out a medication packet	
<b>Medical Diagnosis</b>													
	Diagnosis	Currently Treated by a Physician	History of this condition (not currently being treated)		Diagnosis	Currently Treated by a Physician	History of this condition (not currently being treated)						
	ADD/ADHD				Immune System Compromise								
	Asthma				Lazy Eye								
	Anxiety Disorder				Low Blood Sugar								
	Blindness				Migraine Headaches								
	Color Blind				Nosebleeds								
	Depression				Scoliosis								
	Diabetes				Stomach Aches (Frequent)								
	Eczema				Vision Problems treated with Glasses								
	Gastric Reflux				Vision Problems Treated with Contact Lenses								
	Hearing Impairment				Other								
Comments													

<b>Has your child had surgery?</b> Yes                      No				
<b>If so, please list them:</b>				
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Does your child take any daily or long-term medication?
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Will your child need medication administered at school? If yes, a complete a Medication Administration Packet
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Does your child have any physical limitations, chronic disabilities, or special conditions? If yes, please list and add specific instructions as needed
All students enrolled in Louisiana schools must have current immunizations. Please check one				
<input type="checkbox"/>	My child is current on all immunizations.			
<input type="checkbox"/>	My child is in the process of becoming current on all immunizations.			
<input type="checkbox"/>	I have signed a Louisiana immunization dissent form and submitted a copy to the school nurse. This must be done every school year. See the student handbook for more information.			