

**SAINT JOHN XXIII CATHOLIC SCHOOL**

**HEALTH AND EMERGENCY INFORMATION FORM**

**This form is mandatory for ALL students**

**Please COMPLETE ONE FORM PER CHILD & return to the School Nurse**

<hr/> Student's Name	<hr/> Date of Birth	<hr/> Grade/Room	M   F
<hr/> Student's Address	<hr/> City, State, Zip		
<hr/> Mother's/Legal Guardian's Name	<hr/> Father's/Legal Guardian's Name		
(   )	(   )	(   )	(   )
<hr/> Daytime Phone	<hr/> Cell Phone	<hr/> Daytime Phone	<hr/> Cell Phone
<hr/> Address (if different from Student's)	<hr/> Address (if different from Student's)		
<b>Alternative Emergency Contacts – If Parents Cannot be Reached</b>			

<hr/> Primary Emergency Contact	<hr/> Secondary Emergency Contact
(   )	(   )
<hr/> Daytime Phone	<hr/> Daytime Phone
<hr/> Cell Phone	<hr/> Cell Phone

**Student Health & Medical Information**

<hr/> Allergy to Food/Medication/Other _____	Epipen _____ Benadryl _____
<hr/> Please indicate if your child has any medical conditions not listed:	Asthma _____ Inhaler _____
<hr/>	Diabetes _____ Headache or Migraine _____
<hr/>	Cardiac _____ Seizures _____ I _____
<hr/> Medication child takes regularly: _____	ADD/ADHD _____ Skin _____ Anxiety _____
<hr/>	Autoimmune _____
<hr/> Physician's Name	<hr/> Phone Number
<hr/> Dentist's Name	<hr/> Phone Number
<hr/> Name & Address of Preferred Hospital (if any)	<hr/> Phone Number
<hr/> Insurance Company	<hr/> Group & Policy Number

All students will receive basic first aid and emergency care as needed. By signing this form, I consent to these services being given to my student. I further agree that if emergency service involving medical action or treatment is required and the parent(s) or guardian(s) cannot be contacted, I hereby consent for the Student to be given medical care by the doctor or hospital selected by the School. I hereby give and grant unto any medical doctor or hospital my consent and authorization to render such aid, treatment or care to said student as, in the judgment of said doctor or hospital, may be required, on an emergency basis, in the event the Student should be injured or stricken ill. I authorize the School to release medical information about my student to his/her care provider. I authorize the School to release care and custody of my student to the emergency contacts listed above. It is understood that the consent and authorization given hereby are continuing and apply throughout the current school year. It is further understood that insurance or parent of student will pay any expenses incurred. Payment of such expenses is not a school responsibility.

<hr/> Signature of Parent/Legal Guardian	<hr/> Date
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