

School Year: _____

PLEASE PRINT

Date Received: _____

Grade Level: _____

Our Lady of the Assumption School Health Information Card

STUDENT:

Last Name First Name

M F **DOB:** _____
Circle

ADDRESS:

Street City State Zip County

HEALTH HISTORY (Answer YES or NO)

ALLERGIES (specify): _____

PHYSICAL HANDICAPS (list): _____

ASTHMA: _____ ATTENTION DEFICIT: _____

DIABETES: _____ SEIZURE DISORDER: _____

CANCER: _____ OTHER: _____

Date of last tetanus shot: _____

_____ Does your child take an prescribed medications on a regular basis (at home or at school?) List:

_____ Did your child receive any immunizations this past year? List type/date: _____

EMERGENCY CONTACT INFORMATION

Please indicate custodial parent when applicable.

Father/Guardian: _____ Best form of contact? _____

Phone (home) _____ (work) _____ (cell) _____ (pager) _____

Email (home) _____ (work) _____

Mother/Guardian: _____ Best form of contact? _____

Phone (home) _____ (work) _____ (cell) _____ (pager) _____

Email (home) _____ (work) _____

List two nearby persons who will assume care of your child if parents cannot be reached:

Name: _____ / _____ / _____
home work cell

Relationship: _____

Name: _____ / _____ / _____
home work cell

Relationship: _____

Child's Physician/Pediatrician: _____ Phone: _____

School clinic personnel have my permissions to contact my child's physician for further medical information. In case of serious illness/injury, the school will telephone Emergency Medical Services (911) for immediate transportation to the closest hospital. I, the parent/legal guardian, authorize the transport of and treatment by the hospital emergency staff for my child _____.

Student's Name

Parent Signature: _____ Date: _____

Student's Name

Last

First

Middle