EMERGENCY HEALTH INFORMATION

Student's Name_____Birth Date_____Grade _____

Home Address_____Zip_____Home Ph._____

Work Ph. Of Father/Guardian_____Cell #_____Name_____

Work Ph. Of Mother/Guardian_____Cell #_____Name_____

Email Address_____

Relative, friend or neighbor who has been authorized by parent to pick up child if parent cannot be reached:

Name_____Relationship_____Ph._____

Name_____Relationship_____Ph._____

Medical Insurance: Name_____ID#_____

I understand that the school does not assume responsibility for payment of a physician in any case. However, in an emergency the school may choose a physician. Please state: Yes_____No_____

Name of Doctor_____ Phone_____

Name of Dentist_____ Phone_____

Is your child allergic to any drugs? Yes_____ No_____ If yes, what?_____

Is your child allergic to any foods? Yes_____ No_____ If yes, what?_____

Is your child allergic to other (bee sting, etc.)? Yes_____ No_____ If yes, what?_____

Does your child have any chronic illness (asthma, diabetes, heart disease, epilepsy)?
If yes, what? _____

Does your child take any medicines on a regular basis? Yes_____ No_____
If yes, what and what for? List:
_____

CONSENT FOR TREATMENT

(I) (We), the undersigned parent(s) or legal guardian of _____, a minor, do hereby authorize a representative of St. Agnes School as agent(s) for the undersigned to consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care that is deemed advisable by, and is to be rendered under the general or special supervision of any physician and surgeon licensed under the provisions of the California Medicine Practice Act, the medical staff of an accredited hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but is given to provide authority and power on the part of the above-mentioned agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care that the above mentioned physician in the exercise of his or her best judgment may deem advisable.

This authorization shall remain effective until June 30, 20____ unless sooner revoked in writing and delivered to the above-mentioned agent(s).

Mother's signature _____ Date_____

Father's signature _____ Date_____

Legal Guardian's signature _____ Date_____

Medical History
(to be completed by parent)

1. Health History (check the conditions where appropriate)

_____ Allergy/Asthma	_____ Frequent Leg or Joint Pain	_____ Rubella (3-day)
_____ Allergy to Drugs	_____ Frequent Nosebleeds	_____ Scarlet Fever
_____ Appendectomy	_____ Heart Disease	_____ Shortness of Breath
_____ Cerebral Palsy	_____ Hernia (Rupture)	_____ Sinus Trouble
_____ Concussion	_____ Kidney Disease	_____ Speech Difficulty
_____ Defective Vision	_____ Lameness	_____ Tires Easily
_____ Wears Glasses	_____ Measles (Rubeola)	_____ Tonsillectomy
_____ Diabetes	_____ Mumps	_____ Tuberculosis
_____ Dizziness/Blackouts	_____ Nervousness	
_____ Ear Troubles	_____ Persistent Cough	Dental History
_____ Hearing Loss	_____ Poliomyelitis	_____ Dental Bridge
_____ Epilepsy	_____ Recurrent Boils	_____ False Teeth
_____ Frequent Headaches	_____ Rheumatic Fever	_____ Orthodontia

List any other serious illness, operation or injury and the age when this happened _____

_____

Has your son/daughter had contact with tuberculosis? _____ yes _____ no

If yes, with whom _____

Last contact _____

Has your child ever been advised not to participate in competitive athletics? _____ yes _____ no

If yes, why? _____

Is your child now under care for any medical problem? _____ yes _____ no

If so, please specify _____

Adjustment: Do you feel that your son/daughter has problems of adjustment to friends, to school, or to family that should be brought to the attention of your physician or school personnel? _____ yes _____ no

Comments: _____

Parent/Guardian Signature_____Date_____