Center For Student Learning- Health & Emergency Information

Last name First Name Middle Initial

Grade_____ Date of Birth_____ Male_____Female_____ School year_____

Home Address_____ Home Phone_____
Street Address

_____
City, State, Zip

Father/Guardian Name _____

Email _____Cell#_____Work#_____

Mother/Guardian Name_____

Email_____Cell#_____Work#_____

Child resides with _____

Other persons who are authorized to act for parents/guardian or pick up student in case of an emergency/illness

Name_____Relationship_____ Home/Cell#_____

Name_____Relationship_____Home/Cell#_____

School Health Services Mandated by State Law
Please complete all areas below:

_____ **I consent** for my child to see Dr Ruppersberger and team to perform an annual no cost physical at school, **open to ALL grades**

_____ **I consent** for my child to see St Chris Dental team to perform annual no cost dental care at school, **open to ALL grades**

I **Do NOT consent** to these no cost school services, but rather have my private physician and dentist see my child. I understand Physical examinations are **mandatory for Grades 6 and 9**, and **Dental** examinations are mandatory for grade 7.

Parent Signature_____

ALLERGIES

Severe Allergy (bee sting, food, medication) _____ **List Allergen**_____

Type of reaction (Hives, Rash, Anaphylaxis)_____ **Treatment required**_____

EpiPen ? Yes____* No_____ * Needs physician medication form and emergency plan of care on file*
Medication (name)_____ **Hospitalization** _____

Over the counter Medications **Check consent for school nurses or authorized personnel to administer medications during the school day. The school nurse is authorized to decline to administer medication depending on the situation.**

Tylenol Yes ___ No ___ Ibuprofen Yes ___ No ___ Benadryl Yes ___ No ___

Pepto Bismol Yes ___ No ___ Sudafed PE Yes ___ No ___ Tums Yes ___ No ___

Does your child have a special health problem, chronic conditions or physical limitations, wear glasses/contacts, or have hearing difficulty that the school nurse or teacher needs to know about ? *All Medical conditions need documentation from the Physician
If yes, Explain _____

Family Doctor_____Phone#_____

*** I have read the form completely, and hereby confirm that the above information is correct, and give permission for my child to have those examinations and medications to which I have consented. ***

Parent Signature_____ Date_____