2019-2020 Saint Bernard School Emergency Health Form

Return to the Health Office on or Before the First Day of School

Student Grade __________

Student Name ______________________________ Date of Birth ____________________

Home Address ____ Phone (H) ________________

Father/Guardian's Name ________________________ Phone (W) ____________ Cell _______________

Mother/Guardian's Name _______________________ Phone (W) ____________ Cell ________________

Father's Place of Employment ____

Mother's Place of Employment ____

Student's Physician ___________________________ Dentist ____________________________

Name of adults (other than parents) whom the school may call to dismiss your child if unable to reach you:

1. _____________________________ Relationship_________________ Phone ______________
2. _____________________________ Relationship _________________Phone ______________
3. _____________________________ Relationship _________________Phone ______________

Other School age children living at home:

Name ______________________________________School Attending _______________________

Name ______________________________________School Attending _______________________

Medication Policy

(Please initial after reading each section)

________ All medication my child will require must be brought to the health office by an adult/parent.

________ A complete Saint Bernard Medication Form must be submitted to the health office for all standard doses of acetaminophen (Tylenol), ibuprofen, or cough drops

________ An authorization for the administration of medicines by School Personnel must be completed by your child's physician in the following circumstances:

-for those requiring higher than standard doses of acetaminophen or ibuprofen
-if your child will require acetaminophen or ibuprofen more than 3 times each month
-if your child will require any other over the counter medication (ex: tums, Midol, Claritin, Benadryl, etc)
-if you child will require any prescription medication

________For self-administration of inhalers/Epi-pens, the permission of physician, parent/guardian, and school nurse (including a return demonstration) are required

________ Students are not permitted to carry or distribute any medications while at school

UPDATED HEALTH INFORMATION

1. Can your child participate in all school related activities, including physical education?

   Yes ______ No______ If no, please explain _____________________________________

2. Does your child have any of the following condition? If yes, please explain

Yes	No	
___	___	Food Allergy ____
___	___	Medication Allergy ______________________________________
___	___	Bee Sting Allergy ____
___	___	Latex Allergy ____
___	___	Other Allergies ____
___	___	Asthma ____
___	___	Other Respiratory Condition ______________________________
___	___	Diabetes____
___	___	Seizures ____
___	___	Heart Condition ____
___	___	Urinary Condition _______________________________________
___	___	Hearting Problems ______________________________________
___	___	Vision Problems ____
___	___	Scoliosis ____
___	___	ADHD/ADD ____
___	___	Depression/Anxiety/Mental Health Issue ___________________
___	___	Other Health Condition ___________________________________

3. Please list any serious illness, injury, or surgery your child has had during the past year.

   ____

4. List all medications (prescription and over the counter) that your child takes on a regular or emergency basis (Please include Epi-Pen, inhalers, etc.)

   ____

5. In the event of an emergency requiring an ambulance, which hospital would you like your child transported to : Backus __________________ or Lawrence & Memorial ________________
6. Please contact the school nurse if there is any other medical information that you would like the school nurse to know.
7. I give my permission for the school nurse to share information regarding my child's medical condition(s) with appropriate staff members.

   Signature of Parent/Guardian ________________________________ Date ________________