

**Saint Henry School  
Emergency and Illness Information 2011-2012**

**Student** \_\_\_\_\_ Date of Birth \_\_\_\_\_

Grade \_\_\_\_\_ Teacher \_\_\_\_\_

**Father** \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

**Mother** \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

\*\* For emergency or illness, please state person to be called and number:

First called \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Second called \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Emergency contact if parents are not available:

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Physician \_\_\_\_\_ Phone \_\_\_\_\_

Dentist \_\_\_\_\_ Phone \_\_\_\_\_

**Medical History** – Does student have any of the listed medical conditions?

Asthma       Arthritis       Diabetes       Kidney/Bladder       Visual impairment  
 Bee sting allergy       Hearing Loss       Heart Disease       Headaches/Migraines       contacts  
 Seasonal allergies       Fractures (location) \_\_\_\_\_       Seizure Disorder       glasses

**ALLERGIES** – medication or food \_\_\_\_\_

Diet restrictions \_\_\_\_\_

Physical limitations or activity restrictions \_\_\_\_\_

**Medication** – Name \_\_\_\_\_ Dose \_\_\_\_\_ Frequency \_\_\_\_\_

Name \_\_\_\_\_ Dose \_\_\_\_\_ Frequency \_\_\_\_\_

**Note: Medication given at school must have a physician order and medication release form. (See website under “Our School”).**

Any other medical problem/history that should be communicated to health professionals in the event of an emergency

**INSURANCE:**

Name of Insured \_\_\_\_\_ Company \_\_\_\_\_

Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_

**MEDICAL RELEASE:** In case of serious accident or illness, I authorize school personnel to take emergency measures to protect my child. If the school cannot reach me, I authorize the school to call my child’s physician indicated on this form and follow his/her instructions. If my child’s physician is not available, I authorize the school to take my child to the emergency room.

**Printed Name of parent/guardian\*** \_\_\_\_\_

**Signature of parent/guardian\*** \_\_\_\_\_ **Date** \_\_\_\_\_

\*If legal custody other than parents, name of person(s) or agency \_\_\_\_\_

Appropriate custody paperwork must be attached.