Christ the King School 2016-2017 Health and Emergency Form

Student's Name (Last, First) _______________ Date of Birth _______ Grade/Room _______ Gender M F

Student's Address _______________ City, State, Zip _______________

Mother's/Legal Guardian's Name _______________ Father's/Legal Guardian's Name _______________

Daytime Phone _______ Cell Phone □ Can receive text _______ Daytime Phone _______ Cell Phone □ Can receive text

E-Mail _______________ E-Mail _______________

Student lives with (circle): Both Parents Mother Father Grandparent Other____________________

In case of injury or sudden illness ____ will be called **first.**

The best way to contact me is by phone, e-mail or text. (circle please)

Alternative Emergency Contacts-if Parents cannot be reached

Primary Emergency Contact-relationship to student _______________ Secondary Emergency Contact-relationship to student _______________

(_____)________________(____)______________________ (_____) ____________ (___) ________________

Daytime Phone Cell Phone Daytime Phone Cell Phone

Child **MAY NOT** be picked up by: ____

Student Health & Medical Information

Physician's Name _______ Phone Number _______ Insurance Company _______ Group & Policy Number _______

Student's Allergies—please list what student is allergic to and the reaction they have (rash, hives, nasal congestion, etc.)

- □ Anaphylaxis reaction to ____
- □ Allergies to medication____________________________________ Food Allergies__________________________
- □ Environmental Allergies____________________________________ Seasonal Allergies _______________________
- □ Insect Bites ____ Other: ________________________________

List Medications the Student Takes Daily____

List Medications Student Takes as needed (allergy medications, inhalers, etc.____

STUDENT HEALTH HISTORY

			Details	Year				Details	Year
ADD/ADHD	**Yes**	**No**			**Frequent diarrhea**	**Yes**	**No**		
Asthma	**Yes**	**No**			**Frequent Headaches**	**Yes**	**No**		
Bladder Control Issues	**Yes**	**No**			**Frequent Sore Throats**	**Yes**	**No**		
Cardiac Issues	**Yes**	**No**			**Frequent Stomachaches**	**Yes**	**No**		
Color Deficient	**Yes**	**No**			**Glasses/vision problems**	**Yes**	**No**		
Concussion	**Yes**	**No**			**Gluten Intolerance**	**Yes**	**No**		
Diabetes	**Yes**	**No**			**Hepatitis**	**Yes**	**No**		
Eczema	**Yes**	**No**			**Hives**	**Yes**	**No**		
Emotional Problems	**Yes**	**No**			**Learning Disorder/Dyslexia**	**Yes**	**No**		
Epilepsy (Seizures)	**Yes**	**No**			**Menstrual Cramps**	**Yes**	**No**		
Fainting	**Yes**	**No**			**Migraine Headaches**	**Yes**	**No**		
Frequent Constipation	**Yes**	**No**			**Surgery**	**Yes**	**No**		

List any special concerns or needs that your student has____

(Continued on back side) **SIGNATURES REQUIRED ON BACK PAGE**

All students will receive basic first aid and emergency care as needed. By signing this form, I consent to these services being given to my student. I further agree that if emergency service involving medical action or treatment is required and the parent(s) or guardian(s) cannot be contacted, I hereby consent for the Student to be given medical care by the doctor or hospital selected by the School. I hereby give and grant unto any medical doctor or hospital my consent and authorization to render such aid, treatment or care to said student as, in the judgement of said doctor or hospital, may be required, on an emergency basis, in the event the Student should be injured or stricken ill. I authorize the School to release medical information about my student to his/her care provider as well share information among School staff members to ensure maximum safety and health care for my Student. I authorize the School to release care and custody of my student to the emergency contacts listed above. It is understood that the consent and authorization given hereby are continuing and apply throughout the current school year. It is further understood that insurance or parent of student will pay any expenses incurred. Payment of such expenses is not a school responsibility.

____ ____________________

Signature of Parent/Legal Guardian **Date**

The following items are available in the health office: They MUST be checked in order for your child to receive them.

- ☐ Hand Lotion: for dry skin
- ☐ Sunscreen: for skin protection
- ☐ Cough Drop or Hard Candy: for sore throat/cough
  (Ingredients of supplied items are listed on CTK web site/Health Office)

My signature gives permission for Christ the King School to administer the *above checked items*

____________________________________ ______________________________ ____________

Parent/Guardian Signature **Phone #** **Date**

OVER THE COUNTER MEDICATION PERMISSION

Medication must be provided by the parent in the original, UNOPENED, container and labeled

Please check and indicate the dosage for the Over the Counter Medications provided.

- ☐ **Tylenol/Acetaminophen: DOSE____**
  Administered for: pain, fever, headache, menstrual discomfort
- ☐ **Motrin/Ibuprofen: DOSE____**
  Administered for: pain, fever, headache, menstrual discomfort
- ☐ **Benadryl/Diphenhydramine HCL: DOSE____**
  Administered for itching, rash, allergies
- ☐ **Topical medication name & DOSE____**
  Administered for: cuts, scrapes, rashes
- ☐ **Other-NAME & DOSE ____**

My signature gives permission for Christ the King School to administer the over the counter *medications indicated above.*

____ ____________ _______

Parent/Guardian Signature **Phone #** **Date**