

Student Emergency Health Information
St. Francis of Assisi Preschool

Student's Name _____ Date of Birth _____

Student's Program: PreK-3 _____ PreK-4 _____ Afternoon PreK-3 & PreK-4 _____

Student's Address _____

Custodial Parent/Guardian _____ Relationship _____

Home Phone _____ Cell Phone _____ Pager _____

Place of Employment _____ Phone _____

Second Parent/Guardian _____ Relationship _____

Home Phone _____ Cell Phone _____ Pager _____

Place of Employment _____ Phone _____

Names and Grades of Brothers and Sisters _____

Physician's Name _____ Phone _____

Address _____

Dentist's Name _____ Phone _____

Address _____

Please list names, addresses and phone numbers of persons who may be contacted in the event a parent cannot be located. Only those listed below will be permitted to pick up your child in case of illness or emergency.

Name _____ Home Phone _____ Work Phone _____

Address _____

Name _____ Home Phone _____ Work Phone _____

Address _____

Name and Number of Medical Insurance _____

Current Health Issues: (Such as diabetes, seizures, asthma, etc.) _____

Special Instructions: _____

Health History: (Include past surgeries, serious illnesses, head injuries, etc.) _____

Medications: At Home: _____ At School: _____

Allergies: (Including those to insects, food medications, environmental, etc.) _____

Reaction? _____ EpiPen? Yes _____ No _____

Restrictions: Describe any necessary restrictions or limitations _____

Vision: Does your child wear glasses? _____ Describe any eye/vision problems _____

Eye Doctor (if student has one) _____ Phone _____

Hearing: Describe any hearing problems _____

Ear Doctor (if student has one) _____ Phone _____

The school nurse will keep this information in the nurse's office with other confidential documents. Signing below gives the school nurse permission to share the above information with other school personnel or Emergency Medical Services on a "need to know" basis. I give my permission for emergency transportation and medical treatment. I place the following restrictions on such treatment:

Parent Signature: _____ Date _____