

Health Information

2010-2011

Grade/ Sacrament: _____

FAITH FORMATION: Preschool through Confirmation

Please Print Clearly:

Which is the primary number? (Check)

Mother's Name/ Legal Guardian

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Home Phone: _____

Father's Name/ Legal Guardian

Work Phone: _____

In case of emergency, contact: _____ Phone: _____

(In case either parent can't be reached)

CONSENT TO TREAT:

I (We) the undersigned parent(s) or legal guardian(s) of _____ a minor, do hereby authorize treatment of my (our) child by a licensed medical physician in the case of any accident or illness that may so arise, or any hospitalization necessary, and/or to provide first aid. I (We) further agree to pay any and all costs associated with treatment not covered by my (our) insurance.

Signature of Parent / Legal Guardian: _____ Date: _____

Child's Name: _____

Grade (in Aug.): _____

Age (in Aug.): _____

HEALTH INFORMATION:

Date of Birth (MO/DAY/YR) Family Physician Physicians Phone Number

Health Plan Carrier Health Plan Policy Number Allergies to Drugs or Food

Medication Currently Taking Times & Dosage of Meds Last Tetanus Shot (M/YR)

Please state any **health &/or learning concerns** that your child has that is important for the teacher to know: (such as seizures, asthma, allergies, visual or hearing disabilities, ADHD, difficulty reading or writing, short attention span etc.)

