

**Health Information**

**2011-2012**

**Grade/ Sacrament:** \_\_\_\_\_

**FAITH FORMATION: Preschool through Confirmation**

Please Print Clearly:

Which is the primary number? (Check)

\_\_\_\_\_  
**Mother's Name/ Legal Guardian**

<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>

**Home Phone:** \_\_\_\_\_

**Work Phone:** \_\_\_\_\_

**Cell Phone:** \_\_\_\_\_

**Home Phone:** \_\_\_\_\_

**Work Phone:** \_\_\_\_\_

\_\_\_\_\_  
**Father's Name/ Legal Guardian**

**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.)

\_\_\_\_\_  
\_\_\_\_\_