EMERGENCY HEALTH INFORMATION
2024-25

Student's name:_____ Birth date:_____ Grade:_____

Home address: _____

Father/Guardian:_____ Cell #: _____

Mother/Guardian:_____ Cell #: _____

Relative, friend or neighbor who is authorized by parent to pick up child, if parent cannot be reached:

Name:_____ Cell #: _____

Name:_____ Cell #: _____

I understand that the school does not assume responsibility for payment of a physician in any case. However, in an emergency, the school may choose a physician. Do you consent? ____Yes ____No

Medical insurance:_____ ID #: _____

Doctor's name:_____ Phone #: _____

Dentist's name:_____ Phone #: _____

Is your child allergic to any drugs? ☐ Yes ☐ No If yes, what? _____

Is your child allergic to any foods? ☐ Yes ☐ No If yes, what? _____

Other allergies (bee sting, etc.)? ☐ Yes ☐ No If yes, what? _____

Does your child have any chronic illness (asthma, diabetes, heart disease, epilepsy)? ☐ Yes ☐ No
If yes, what? _____

Does your child take any medicines on a regular basis? ___ Yes ____ No
If yes, what and to treat what? _____

CONSENT FOR TREATMENT

I/We, the undersigned parent(s) or legal guardian of_____, a minor, do hereby authorize a representative of St. Agnes School as agent(s) for the undersigned to consent to any xray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care that is deemed advisable by, and is to be rendered under the general or special supervision of any physician and surgeon licensed under the provisions of the California Medicine Practice Act, the medical staff of an accredited hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but is given to provide authority and power on the part of the above-mentioned agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care that the above mentioned physician in the exercise of his or her best judgment may deem advisable.

This authorization shall remain effective until June 30, 20____unless revoked sooner in writing..

Mother's signature:_____ Date _____

Fathers signature:_____ Date _____

Guardian's signature:_____ Date _____

MEDICAL HISTORY

(to be completed by parent)

Health history (check all that apply)

- ☐ Allergy/asthma
- ☐ Allergy to drugs
- ☐ Appendectomy
- ☐ Cerebral palsy
- ☐ Concussion
- ☐ Defective vision
- ☐ Wears glasses
- ☐ Diabetes
- ☐ Dizziness/blackouts
- ☐ Persistent cough
- ☐ Poliomyelitis
- ☐ Rheumatic fever
- ☐ Frequent leg or joint pain
- ☐ Frequent nosebleeds
- ☐ Heart disease
- ☐ Hernia (rupture)
- ☐ Kidney disease
- ☐ Lameness
- ☐ Measles (Rubeola)
- ☐ Mumps
- ☐ Nervousness
- ☐ Hearing loss
- ☐ Epilepsy
- ☐ Rubella (3-day)
- ☐ Scarlet fever
- ☐ Shortness of breath
- ☐ Sinus trouble
- ☐ Speech difficulty
- ☐ Tires easily
- ☐ Tonsillectomy
- ☐ Tuberculosis
- ☐ Ear troubles
- ☐ Frequent headaches
- ☐ Recurrent boils

Dental history ☐ Dental bridge ☐ False teeth ☐ Orthodontia

List any other serious illness, operation, or injury, and the age it happened: _____

_____

Has your son/daughter had contact with tuberculosis? ☐ Yes ☐ No If yes, with whom, and when was their last contact? _____

_____

Has your child ever been advised not to participate in competitive athletics? ☐ Yes ☐ No If yes, why? _____

_____

Is your child now under care for any medical problem? ☐ Yes ☐ No If yes, for what concern? _____

_____

Do you feel that your child has problems with adjusting to friends, school, or family that should be brought to the attention of your physician or school personnel? ☐ Yes ☐ No If yes, please explain: _____

_____

Additional comments: _____

_____

Parent's name (printed) _____

Parent's signature: _____ Date _____