



# EMERGENCY HEALTH INFORMATION

## 2026-27

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)

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

**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 \_\_\_\_\_