A Roman Catholic School

St. Rocco School

Sharing the Love of the Heart of Christ!

Emergency Medical Information 2024-2025

Female _____ Male _____

Student Name: _____ Grade: ____

Date of Birth: ____-___-____

Address: _____ Phone: _____

Street City State Zip

Mother:

Name: _____

Home Phone: _____

Employer: _____

Work Phone: _____

Cell Phone: _____

Email: _____

Father:

Name: _____

Home Phone: _____

Employer: _____

Work Phone: _____

Cell Phone: _____

Email: _____

OTHER CONTACTS: (Please list two (2) persons who are authorized to pick up your child. They must be available during school hours.)

1. _____

Name Phone # Relationship to Child

2. _____

Name Phone # Relationship to Child

3. _____

Name Phone # Relationship to Child

Siblings at SRS/Grade: _____

Primary Physician/Pediatrician_____ Physician's Phone_____

Preferred Hospital: _____

Health Insurance: _____

Insurance Policy #: _____

May we contact your doctor if necessary?

_____Yes _____No

PLEASE COMPLETE THE FOLLOWING:

In the event of an emergency, I grant permission for my child to be transported to the hospital: _____Yes ____No

I grant permission for my child to be given ( )non-medicated throat lozenges ( ) Tylenol ( ) Advil ( ) Tums or generic equivalents; per JPS, School Health Services Policies and Procedures and/or School Nurse's discretion.

_____ _____

SIGNATURE OF PARENT/GUARDIAN **DATE**

Unless otherwise directed **in writing,** disclosure of information pertinent to the health of the child listed on this card may be shared with school employees, transportation staff, and/or others who deal in the care of this child.

PLEASE INFORM THE SCHOOL OF ANY INFORMATION CHANGES DURING THE SCHOOL YEAR.

PLEASE COMPLETE OTHER SIDE

STUDENT HEALTH HISTORY

Has your child ever had or have any of the following?

	NO	YES	YEAR		NO	YES	YEAR
Chicken Pox				Spinal Bifida			
Measles				Cerebral Palsy			
Mumps				Downs Syndrome			
Rubella German Measles				Cystic Fibrosis			
Pertussis Whooping Cough				Cancer			
Tuberculosis				Hemophilia			
Pneumonia				Seizure Disorder			
Diabetes				Asthma			
Eczema				Heart Condition			
Any bone or muscle condition				Kidney Disease			
Muscular Dystrophy				Anemia			

Is your child prone to the following?

	NO	YES		NO	YES
Frequent Headaches			Tonsillitis		
Fainting			Nose bleeds		
Frequent colds			Frequent urination		
Shortness of breath			Gastrointestinal upset		
Strep throat			Nervous habits		
Ear infections			Dizzy Spells		
Hearing problems			Other, please explain		

If you answered yes to any of the above, please elaborate:

_____

_____

Does your child take any medication? Yes _____ No _____

If yes, name the medication and dose _____

Does your child have allergies? Yes _____ No _____

Food _____ Animals, Insects, Chemicals _____ Medication _____ Environment _____

Please explain how your child reacts and the severity of the reaction. (Rash, wheezing, etc.)

_____

_____

Does your child require medication for the allergic reaction? Yes_____ No _____

If yes, what is the medication _____

Are there any health problems that would interfere with your child's school activities?

Yes_____ No_____ Explain: _____

Please give any additional health information _____

_____