Resurrection
COLLEGE PREP HIGH SCHOOL
Caritate et Veritate

Emergency Information

This form is to be completed by the Parent/Guardian. The form must be submitted to the Records Office by **Monday, August 10, 2020**. In an emergency, school will contact the Parents first. It is the Parent's responsibility to update the information on this form. Please print.

Student Information

Last	First	Middle	Date of Birth	Grade

Parent/Guardian Contact Information

Parent Name	Last	First	Lives with student ___yes ___no Relationship:	Home Telephone
Address		Apt. #		Cell Telephone
City	State		Zip	Work Telephone
Email:				
Parent Name	Last	First	Lives with student ___yes ___no Relationship:	Home Telephone
Address		Apt. #		Cell Telephone
City	State		Zip	Work Telephone
Email:				

Other Contact Information

Please list at least two other adults we may call if the parent(s) cannot be reached in an emergency. Individuals listed below also have your permission to pick your daughter up from school during the school day or in the event of an emergency school closing.

Name		Relationship to Student
Home Phone	Work Phone	Cell Phone
Name		Relationship to Student
Home Phone	Work Phone	Cell Phone
Name		Relationship to Student
Home Phone	Work Phone	Cell Phone
Name		Relationship to Student
Home Phone	Work Phone	Cell Phone
Name		Relationship to Student
Home Phone	Work Phone	Cell Phone

Parent /Guardian Signature_____ Date_____

Please turn over and complete medical information section on the back of this form.

Student Heath Information

Please check any current or chronic health conditions that may affect your daughter during the school day.

Allergies/Environmental	Yes		Bone/Joint/Muscular Disorder	Yes	
Allergies/Food*	Yes		Diabetes	Yes	
Allergies/Insect Stings or Bee	Yes		Dizziness or Fainting	Yes	
Allergies/Medications*	Yes		Digestive/Bowel Problems	Yes	
Allergies/Others*	Yes		Hearing Issues/Hearing Aid*	Yes	
Asthma/Breathing Problems*	Yes		Heart-related Illness	Yes	
Bladder/Kidney Disorder	Yes		Seizure or Epilepsy*	Yes	
Bleeding/Clotting Disorder	Yes		Vision or Eye Disorder*	Yes	

If your daughter has a medical condition for which she has a health plan. please contact her School Counselor or the Dean of Students. Students who take medications during the school day must submit the Physician's Request to Self-Medicate and Parent Authorization to Self-Medicate forms prior to bringing the medicine to school. These forms must be updated and submitted annually each school year.

Provide details regarding:

Allergies: Allergic to the following foods _____

Allergic to the following medicines_____

Does your daughter carry an EpiPen? ___ Yes ___ No

Asthma: Does your daughter carry an inhaler? ___ Yes ___ No If yes, specify _____

What triggers your daughter's asthma attack? _____

Describe the symptoms your daughter experiences before or during an asthma attack. Check all that apply:

___ Coughing ___Shortness of breath ___Wheezing ___"Tightness" in chest ___Breathing hard/fast ___Feeling tired/weak

Other_____

Diabetes: ___ Type 1 ___ Type 2

Please contact your daughter's Guidance Counselor or the Dean of Students to complete a Diabetic Care plan which will be followed during the school day.

Hearing: Does your daughter wear a hearing aid? ___Yes ___No

Does your daughter need to be seated near the teacher in order to hear well? ___Yes ___No

Seizure: Seizure history _____

If she takes medication for seizures, please list: _____

Vision: Does your daughter wear ___Glasses ___Contact Lenses Does your daughter need to be seated at the front of the classroom? ___Yes ___No

If you checked Yes to any other medical condition or your daughter has a medical condition not listed, please explain.

_____

_____

I give permission to the school to share information relevant to my daughter's health condition with school personnel and emergency medical professionals when necessary to meet her health and safety needs.

Parent/Guardian Signature _____ Date_____