Bishop O'Gorman Summer Care Program
Health Emergency Card

**** Please complete one Health Emergency Card per family. ****

Please print all information. In case of summer care-related accidents, illness or summer care dismissal communication, please complete.

FAMILY NAME: _____

Child #1: _____ Date of Birth: _____ Age:____ Current Grade:_____

Ethnicity of Student: ❑ Hispanic/Latino ❑ Non-Hispanic/Latino **Race of Student (Mark all that apply):**
❑ American Indian or Alaska Native ❑ Asian ❑ Black or African American ❑ Native Hawaiian or Other Pacific Islander ❑ White

Child #2: _____ Date of Birth: _____ Age:____ Current Grade:_____

Ethnicity of Student: ❑ Hispanic/Latino ❑ Non-Hispanic/Latino **Race of Student (Mark all that apply):**
❑ American Indian or Alaska Native ❑ Asian ❑ Black or African American ❑ Native Hawaiian or Other Pacific Islander ❑ White

Child #3: _____ Date of Birth: _____ Age:____ Current Grade:_____

Ethnicity of Student: ❑ Hispanic/Latino ❑ Non-Hispanic/Latino **Race of Student (Mark all that apply):**
❑ American Indian or Alaska Native ❑ Asian ❑ Black or African American ❑ Native Hawaiian or Other Pacific Islander ❑ White

Child #4: _____ Date of Birth: _____ Age:____ Current Grade:_____

Ethnicity of Student: ❑ Hispanic/Latino ❑ Non-Hispanic/Latino **Race of Student (Mark all that apply):**
❑ American Indian or Alaska Native ❑ Asian ❑ Black or African American ❑ Native Hawaiian or Other Pacific Islander ❑ White

Hospital Preference: Avera McKennan / Sanford

Physician First and Last Name:_____ Phone #:_____

Medical Conditions, Allergies, or Medications (please state clearly which child):

If my child needs the following, I authorize summer care personnel to administer (check all that apply):

❑ **Acetaminophen (Tylenol)** ❑ **Ibuprofen (Advil/Motrin)**

Administration of "over the counter" medication will be at the discretion of the appointed personnel, consistent with the recommended dose for age as defined on package guidelines.

Medical Release:

I hereby consent to any medical services that may be required while my child is under the supervision of an employee of the Bishop O'Gorman Catholic Schools Summer Care program and hereby appoint a Summer Care employee to act on my behalf in securing necessary medical services from any duly licensed physician or medical emergency provider. Responsibility for payment of ambulance, physician and/or hospital is that of the parent or guardian.

❑ **Yes, I agree to the above medical release.**

Parent Signature: _____ Date: _____

You must notify the school if any of the above information changes.