School Year: 20_____- 20_____
LAST NAME_____
TEACHER/HOMEROOM_____
GRADE_____

Saint Theresa Elementary and Middle School
Student Information Update

To Parents or Guardians: Please complete BOTH SIDES of this form to help the school nurse and administrators plan for the health and emergency needs of your student and facilitate their educational experience.

DEMOGRAPHIC INFORMATION

Student Name: _____ Birth Date: _____

Address: _____ Home Phone: _____

Parent/Guardian: _____ Employer Name/Work #: _____

Email: _____ Cell Phone #: _____

Parent/Guardian: _____ Employer Name/Work #: _____

Email: _____ Cell Phone #: _____

Student lives with: _____

EMERGENCY CONTACTS AND EMERGENCY STUDENT PICK-UP

Please identify below the adults, other than the parents/guardians listed above, that you give permission to notify and/or to pick up your child(ren) in the event of an emergency.

Priority	Name	M/F	Relationship to Student	Phone	Phone Type	Emergency Pick-up
1						Y N
2						Y N
3						Y N
4						Y N
5						Y N

I hereby give Saint Theresa Elementary and Middle School permission to release my child to ONLY those adults listed above. I understand that, with my signature below, the school will NOT allow any other adult to pick up my child in the event of an emergency.

Parent/Guardian Signature: _____ Date: _____

Medical History/Medication Administration 20___-20___

Student Name: _____ **Birth Date:** _____ **Grade** _____

Student's Physician: _____ Student's Dentist: _____
Phone #: _____ Phone #: _____

Hospital Preference: _____

Please circle "yes" or "no" concerning your student's medical history and explain the type care needed for the "yes" responses.

Yes No **ADD/ADHD** _____
Yes No **Asthma** _____ *Exercise-induced?* _____
What triggers an attack? _____ *What controls an attack?** _____
Yes No **Diabetes** _____
Yes No **FOOD or DRUG ALLERGY** _____
*Requires Benadryl?** _____ *Requires Epinephrine?** _____
Yes No **BEESTING ALLERGY** _____
*Requires Benadryl?** _____ *Requires Epinephrine?** _____
Yes No **Seizure Disorder/Epilepsy** _____
Yes No **Condition Limiting Activity or Physical Education** _____
Yes No **Surgery in past year or other conditions requiring ongoing care by physician** _____
Yes No **Special Dietary Needs** _____
Yes No **Chronic or recurring condition or diagnosis** _____
Yes No **Changes in the family during the past year which may affect school performance**
_____

Current medication: Name _____ **Dosage** _____ **Frequency** _____
Current medication: Name _____ **Dosage** _____ **Frequency** _____
Current medication: Name _____ **Dosage** _____ **Frequency** _____

***A medication permission form needs to be completed annually by a physician and parent for inhalers, epi-pens, and any prescription medications that are to be given at school.**

Consent Data

I give my permission to the school nurse to administer the following medications to my child according to the school district's standing orders (from whom St. Theresa School receives its medical services). Medical Standing Orders are available for your review. I hereby release West Shore School District and St. Theresa School and all its employees from any and all liability for a adverse effects or injuries my child may suffer as a result of this request.

Yes No Acetaminophen (Tylenol)
Yes No Bacitracin (Antibiotic Ointment)
Yes No Ibuprofen (Advil, Motin)
Yes No Benadryl
Yes No Calamine Lotion
Yes No Antacid (Tums)
Yes No Hydrocortisone cream
Yes No Cough Drops/Throat Lozenges
Yes No Orajel/Anbesol/Benzocaine

Yes No I give the school nurse permission to discuss allergies and medical conditions as needed with the school staff. Please list exceptions _____
Yes No I give permission for the school nurse to contact me via email for health related issues.
Yes No I give permission to the school nurse to exchange information with my child's primary care provider for Immunization information, medication administration questions or in an emergency.

Parent/Guardian Printed Name: _____

Parent/Guardian Signature: _____ **Date** _____