2024-2025 Saint Bernard School Emergency Health Form

Return to the Health Office on or Before the First Day of School

Student Grade _____

Student Name _____ Date of Birth _____

Home Address _____ Phone (H) _____

Father/Guardian's Name _____ Phone (W) _____ Cell _____

Mother/Guardian's Name _____ Phone (W) _____ Cell _____

Father's Place of Employment _____

Mother's Place of Employment _____

Student's Physician _____ Dentist _____

Name of adults (other than parents) whom the school may call to dismiss your child if unable to reach you:

1. _____ Relationship_____ Phone _____
2. _____ Relationship _____Phone _____
3. _____ Relationship _____Phone _____

Other School age children living at home:

Name _____School Attending _____

Name _____School Attending _____

Medication Policy

(Please initial after reading each section)

_____ All prescription medication my child will require must be brought to the health office by an adult/parent.

_____ A complete Saint Bernard Medication Form must be submitted to the health office for all standard doses of acetaminophen (Tylenol), ibuprofen, or cough drops

_____ An authorization for the administration of medicines by School Personnel must be completed by your child's physician in the following circumstances:

-for those requiring higher than standard doses of acetaminophen or ibuprofen
-if your child will require acetaminophen or ibuprofen more than 3 times each month
-if your child will require any other over the counter medication (ex: tums, Midol, Claritin, Benadryl, etc)
-if you child will require any prescription medication

_____For self-administration of inhalers/Epi-pens, the permission of physician, parent/guardian, and school nurse (including a return demonstration) are required

_____ Students are not permitted to carry or distribute any medications while at school

UPDATED HEALTH INFORMATION

1. Can your child participate in all school related activities, including physical education?

   Yes _____ No_____ If no, please explain _____

2. Does your child have any of the following condition? If yes, please explain

Yes	No	
___	___	Food Allergy _____
___	___	Medication Allergy _____
___	___	Bee Sting Allergy _____
___	___	Latex Allergy _____
___	___	Other Allergies _____
___	___	Asthma _____
___	___	Other Respiratory Condition _____
___	___	Diabetes_____
___	___	Seizures _____
___	___	Heart Condition _____
___	___	Urinary Condition _____
___	___	Hearing Problems _____
___	___	Vision Problems _____
___	___	Scoliosis _____
___	___	ADHD/ADD _____
___	___	Depression/Anxiety/Mental Health Issue _____
___	___	Other Health Condition _____

3. Please list any serious illness, injury, or surgery your child has had during the past year.

   _____

4. List all medications (prescription and over the counter) that your child takes on a regular or emergency basis (Please include Epi-Pen, inhalers, etc.)

   _____

   Please contact the school nurse if there is any other medical information that you would like the school nurse to know.

5. I give my permission for the school nurse to share information regarding my child's medical condition(s) with appropriate staff members.

   Signature of Parent/Guardian _____ Date _____