

2026-2027 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; students may carry their own 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 is necessary to discuss.

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 _____