Student Emergency / Medical Information

First Name: _____ Last Name: _____ DOB: _____

School: St. Cecilia Catholic School Rome/Sec: _____ Grade: _____

Home Address: _____ Home Phone: _____

Mother: _____ Email: _____ Cell Phone: _____

Father: _____ Email: _____ Cell Phone: _____

Guardian: _____ Email: _____ Cell Phone: _____

Emergency contacts (other than parents) must be local and available for contact:

Name and Relationship to child **Phone Number:**

1) _____

2) _____

Dentist: _____ Phone: _____

Child's Doctor/Clinic:

_____ Phone: _____

Medical Insurance: MA ____ CHIP ____ Private: _____

Insurance Company Name: _____ Policy #: _____

Please circle below to give permission to the school nurse to give your child medication.

Acetaminophen (Tylenol)	Yes	No
Ibuprofen	Yes	No
Topical Hydrocortone	Yes	No

Please **CIRCLE** the following if your child:

Wears: Glasses Hearing Aid

Has: Seizures Diabetes Asthma ADHD

List Allergies: (Food substitution requires a new order yearly from a health care provider) _____

_____

Other Health Problems: _____

Does your child take medication? Yes (please list) _____ No _____

Medication	Dose	Frequency/Time	Reason

Your signature gives permission for emergency treatment; as well as for SDP School Nurses to administer medications you indicate on this emergency form, during school hours, on field trips, and after school activities. I authorize the school nurse to communicate with my child's health care provider and my health care provider to reply as needed regarding my child's care.

Parent/Guardian Signature: _____ Date: _____