Health Information 2014-2015 **Grade/ Sacrament: _____**

FAITH FORMATION: Preschool through Confirmation

Please Print Clearly:

_____

Mother's Name/ Legal Guardian

_____

Father's Name/ Legal Guardian

Which is the primary number? (Check)

- ☐ **Home Phone**: _____
- ☐ **Work Phone**: _____
- ☐ **Cell Phone**: _____
- ☐ **Home Phone**: _____
- ☐ **Work Phone**: _____

In case of emergency, contact: _____ Phone: _____

(In case either parent can't be reached)

CONSENT TO TREAT:

I (We) the undersigned parent(s) or legal guardian(s) of_____ a minor, do hereby authorize treatment of my (our) child by a licensed medical physician in the case of any accident or illness that may so arise, or any hospitalization necessary, and/or to provide first aid. I (We) further agree to pay any and all costs associated with treatment not covered by my (our) insurance.

Signature of Parent / Legal Guardian: _____ Date: _____

Child's Name: _____

Grade (in Aug.):_____ **Age (in Aug.):_____**

HEALTH INFORMATION:

_____

Date of Birth (MO/DAY/YR) **Family Physician** **Physicians Phone Number**

_____

Health Plan Carrier **Health Plan Policy Number** **Allergies to Drugs or Food**

_____

Medication Currently Taking **Times & Dosage of Meds** **Last Tetanus Shot (M/YR)**

Please state any **health &/or learning concerns** that your child has that is important for the teacher to know: **(such as seizures, asthma, allergies, visual or hearing disabilities, ADHD, difficulty reading or writing, short attention span etc.)**

_____

_____