CARDINAL STRITCH CATHOLIC HIGH SCHOOL & ACADEMY

EMERGENCY MEDICAL INFORMATION FORM
(PreK-12 School and Athletic Use)

Purpose: To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority when parents or guardians cannot be reached.

Student ____ **Grade**_______ **Birthdate**_____________
Last name, First name

Mother____
Last name, First name

Phone: Home ______________________ **Work** ______________________ **Cell** ____________________

Father____
Last name, First name

Phone: Home ______________________ **Work** ______________________ **Cell** ____________________

In case of emergency, if parent or guardian cannot be reached, please contact & release my child to:

Name_____________________ **Phone**___________________________ **Relationship**________________

Name_____________________ **Phone**___________________________ **Relationship**________________

Name_____________________ **Phone**___________________________ **Relationship**________________

☐ **If you have less than 3 emergency contacts, please check box and sign below.**

Parent Signature ____

EXTENDED DAY PROGRAM (EDP) REGISTRATION (PreK-8)

(THIS SECTION IS REQUIRED TO BE COMPLETED FOR ALL STUDENTS IN GRADES PreK TO 8)

In addition to the contacts listed above, my child may be released from EDP to the following people:

1. ____________________________________ 2. ____

3. ____________________________________ 4. ____

Estimated EDP Use: ***(please check any that apply)***

☐ **Daily** ☐ **Several times a week** ☐ **Occasionally** ☐ **Not at all**

☐ **Morning** ☐ **Afternoon**

 ADMISSION DATE: 2017-18 school year

PLEASE FILL OUT BOTH SIDES **(Please complete with black/blue ink)**

Student ____ **Grade**_______ **Birthdate**______________
Last name, First name

I give my permission for the school to administer aspirin-free medication to my child during the school day, if needed.

☐ **Yes** ☐ **No** **Parent Signature**____

STUDENT HEALTH HISTORY

Emotional Problems (i.e. Anxiety, hysteria)____

☐ **Diabetes** ☐ **Epilepsy** ☐ **Rheumatic Fever**

Allergies ____ **Tetanus** (last injection date)_________________

Any present health problems or under any medical treatment:____

____

Prescription Medications: ____
(include anti-convulsion, antihistamines, insulin, etc.)
Note: If student needs to take any prescription medication (including an inhaler) during the school day, the parent MUST fill out an Authorization to Administer Medication Form. Pick up these forms in the Main Office.

PART I OR II MUST BE COMPLETED

PART I: TO GRANT CONSENT

Insurance Provider_____________________________________ **Group Number** ______________________

Policy Holder ____ **Subscriber Number** ___________________

Other Pertinent information____

I hereby give consent for the following medical care providers and local hospital to be called:

Physician____ **Phone**_______________________

Dentist ____ **Phone**_______________________

Medical Specialist ____ **Phone**_______________________

Preferred Hospital ____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by the above-named doctors, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to any hospital reasonably accessible.
This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Signature of Parent/Guardian____ **Date**_________________

OR

PART II: TO REFUSE CONSENT
I **DO NOT** give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take the following actions:

____

Signature of Parent/Guardian____ **Date**_________________