St. Joan of Arc School
School Health Emergency Forms (2021-2022)

Student Last Name:	First Name:	Middle Initial:
Address:		

County of Residence:	Gender: **M** **F**	DOB:	Religion:	Grade:

Ethnicity:

___ Asian/Pacific Islander (P) ___ Black/African American (B) ___ Hispanic (H)
___ Multi-Racial (M) ___ Native American (I) ___ White/Caucasian (W)

SECTION ONE – STUDENT EMERGENCY CONTACT INFORMATION

In the event your child becomes sick or injured and needs to be sent home or to the ER, the school office will always attempt to reach the Parent/Guardian Listed below FIRST. Secondary Contacts will be called if the parent/guardian cannot be reached. PLEASE KEEP THESE NUMBERS CURRENT!

1. Parent/Guardian Name: Check all that apply: ☐ Lives with ☐ Legal Guardian	ADDRESS:	Home Number: Cell Number: Work Number:
2. Parent/Guardian Name: Check all that apply: ☐ Lives with ☐ Legal Guardian	ADDRESS:	Home Number: Cell Number: Work Number:

Emergency Contact List		Relationship	Phone #1	Phone #2	Phone #3
1.					
2.					
3.					

Medication Policy Review

All medications (both prescription and over-the counter) MUST be sent in to school for your child. All MUST have a signed physician Medication and Permission Form!!!!

Prescription medications MUST be in a prescription bottle labeled by your pharmacist.

Any OTC medication must be supplied by you. NO STOCK MEDICATIONS WILL BE AVAILABLE.

PARENTS OR ANOTHER ADULT must hand carry the medications(s) to the school office.

In EMERGENCIES requiring immediate medical attention, your child will be taken to the NEAREST hospital Emergency Room. Your signature authorizes the responsible person at the school or Extended Care (if applicable) for your child to be transported to that hospital. This also gives us permission to contact your child's health provider if needed.

It is the responsibility of the parent/guardian to notify the school office of any changes in the student's health status during the school year.

Parent/Guardian Signature: _____Date: _____

Parent/Guardian Signature:_____ Date: _____

Thank you very much for the time to complete this form. Parent/Guardian signatures are good for the 2021/2021School Year only. This form must be updated annually.

HEALTH HISTORY

STUDENT HEALTH INFORMATION	Please answer the following questions pertaining to your child	
Student's Legal LAST Name	**Suffix Student's Legal FIRST Name**	**Student's Legal MIDDLE Name**

ADHD/ADD ☐Yes ☐No	Is medication needed at school?* ☐ Yes ☐ No
Allergies ☐Yes ☐No	What is your child allergic to?* Please list:
	Describe allergic reaction:
☐Food ☐Seasonal ☐Medication	Has your child received emergency care in the past related to allergy? ☐Yes ☐No
Has your child been stung by a bee? ☐Yes ☐No	Does your child have an Epi Pen? ☐ Yes ☐No
	Will your child need an Epi Pen at school?* ☐Yes ☐No
Asthma ☐Yes ☐No	If yes, date of last attack*:
	Diagnosed by a doctor? ☐Yes ☐No
	Medication taken at home:
	Is medication needed at school?* ☐Yes ☐No
Diabetes ☐Yes ☐No	Does your child use insulin? ☐Yes ☐No
	Does your child use oral medication? ☐Yes ☐No
	Is medication needed at school?* ☐Yes ☐No
	Is blood sugar monitoring needed at school?* ☐Yes ☐No
	Is Glucagon injection needed at school?* ☐Yes ☐No
Seizures Yes No	If yes, please describe seizure*: ☐Yes ☐No
	Does your child take seizure medication at home? ☐Yes ☐No
	Is medication needed at school?* ☐Yes ☐No
	Is your child currently under a doctor's care for seizures? ☐Yes ☐No
	When was his/her last seizure?
Migraines Yes No	Is medication needed at school?* ☐Yes ☐No
Head Injury/Concussion Yes No	Has your child been diagnosed with a concussion in the past year? ☐Yes ☐No
	Date of injury:
	Is your child currently under a doctor's care for this condition? ☐Yes ☐No
Vision/Eye Concerns Yes No	Please list any vision concerns:
	Does your child wear glasses or contacts? ☐Yes ☐No
Hearing/Ear Concerns Yes No	Does your child have a known hearing loss? ☐Yes ☐No If yes, please indicate affected ear: ☐Right ☐Left ☐Both
	Does your child wear a hearing aid? ☐Yes ☐No If yes, please indicate which ear: ☐Right ☐Left ☐Both
Heart Condition Yes No	If yes, please list condition*:
	Does your child take medication for this condition? ☐Yes ☐No
	Is exercise limited?* Yes No
Mental/Emotional Yes No	If yes, please list services that have been provided for your child*:
Other Health Concerns Yes No	If yes, please describe*:
	Will your child need special procedures performed at school?* ☐Yes ☐No Type of health care procedure needed:
Does your child take medications daily at home? ☐Yes ☐No If "yes," please list:	
Special Instructions for teacher and/or school nurse:	
*ADDITIONAL FORMS ARE REQUIRED TO BE COMPLETED BY A PHYSICIAN AND REVIEWED BY THE SCHOOL NURSE BEFORE ANY HEALTH ACCOMMODATIONS CAN BE MADE. SOME ACCOMMODATIONS MAY REQUIRE A DELAYED ENROLLMENT DATE	