St. John Vianney Catholic School
EMERGENCY FORM

Student Name_____ **Grade**_____
Last First M.I.

Date of Birth_____ **Gender**_____

Address_____ **City**_____ **Zip**_____

Preferred Doctor_____ **Phone**_____

Dentist_____ **Phone**_____

Preferred Hospital_____

Insurance_____ **Policy#**_____ **Group#**_____

Please check answers to questions1-8 below. Explain "yes" answers on space below.

1. YES ☐ NO ☐ ANY CONCERNS ABOUT GENERAL HEALTH (EATING AND SLEEPING HABITS, WEIGHT, ETC.)
2. YES ☐ NO ☐ ANY OTHER SPECIFIC ILLNESS OR SOCIAL/EMOTIONAL OR BEHAVIOR PROBLEMS?
3. YES ☐ NO ☐ ANY ALLERGIES (FOOD, INSECTS, MEDICATIONS, ETC)? SYMPTOMS THAT OCCUR:

   _____

   _____
4. YES ☐ NO ☐ ANY PRESCRIPTION MEDICATION (DAILY OR OCCASIONALLY) ?
5. YES ☐ NO ☐ ANY PROBLEMS WITH VISION, HEARING, OR SPEECH (GLASSES, CONTACTS, EAR TUBES, ETC)
6. YES ☐ NO ☐ ANY HOSPITALIZATION, OPERATION, OR MAJOR ILLNESS (SPECIFY PROBLEM)?
7. YES ☐ NO ☐ ANY SIGNIFICANT INJURY OR ACCIDENT (SPECIFY PROBLEM) ?

   YES ☐ NO ☐ WOULD YOU LIKE TO DISCUSS ANYTHING ABOUT YOUR CHILD'S HEALTH WITH A SCHOOL NURSE? _____

   _____

PARENT/GUARDIAN INFORMATION (ENTER IN SEQUENCE TO BE CONTACTED)

NAME_____ **PHONE**_____ **CELL**_____

ADDRESS_____ **ZIP**_____

EMPLOYER_____ **WORK**_____

EMAIL_____

NAME_____ **PHONE**_____ **CELL**_____

ADDRESS_____ **ZIP**_____

EMPLOYER_____ **WORK**_____

EMAIL_____

IF THE ABOVE CANNOT BE REACHED, CONTACT _____

RELATIONSHIP_____ **PHONE**_____ **CELL**_____

SCHOOL HEALTH SERVICES

I hereby give my consent for this child to participate in the School Health Services Program. MY child will receive emergency care in school and health screenings which may include vision, hearing, dental, growth and development and scoliosis as per State Guidelines.

In the event of a serious accident or illness and I cannot be reached, I hereby authorize the school to contact the physician or dentist and for those professions to provide protected health information.

In the event of an EMERGENCY, I understand that the school will access the 911 emergency medical system immediately. T o expedite care, I give my permission for school personnel to provide medical information to the responding emergency team to initiate treatment, and to transport to the appropriate facility. I request to be notified of my child's condition and admission as soon as possible. If I cannot be reached, I request that the admitting facility notify one of the other persons listed above my child's condition and admission. I agree to be financially responsible for my child's total treatment and transport.

I have reviewed the above information and have made corrections as needed.

PARENT/GUARDIAN_____ DATE_____