ACADEMY OF THE HOLY FAMILY
Telephone (860) 822-9272

PERMISSION FOR EMERGENCY CARE
FAX (860) 822-1318

(To be completed by parent/guardian before the beginning of school year)

Name of Student__________________________________ ***Grade***_____ ***Social Security #***______________________

Address____
Street

____
City State Zip Code Country

Student's Date of Birth: __________________________________ ***Home Phone #***_________________________

Student Lives With: ☐ Both Parents ☐Father Only ☐ Mother Only

☐ Father/Stepmother ☐ Mother/Stepfather ☐ Grandparents ☐ Guardian ☐ Other

Mother' Name_____________________________ ***Work Phone #*** _________________________ ***Hours*** _____

Mother's Address____
(If Different) *Street* *City/State/Zip Code* *Country*

Mother's E-Mail Address___________________________________ ***Cell/Pager #*** ______________________________

Mother's Workplace & Address____

Father's Name______________________________ ***Work Phone #***_________________________ ***Hours***_________

Father's Address____
(If Different) *Street* *City/State/Zip Code* *Country*

Father's E-Mail Address____________________________________ ***Cell/Pager #***_____________________________

Father's Workplace & Address____

Name of Person(s) or Agency Having Legal Custody____

Address____
Street City/State/Zip Code Country

If Student Lives Between Two Households, Please Designate Emergency Contact:

Name/Relationship____ Phone Number(s)______________________

*Parent **NOT** Authorized to pick up student from school (**Must have court papers)***

Name____ ***Relationship***___________________________________

Emergency Contact: In the event a parent cannot be reached, **you must** give the name, address, and phone number of two persons who could pick up and take your daughter home in a timely manner.

1) ____
Name Address Relationship Phone #

2) ____
Name Address Relationship Phone #

I agree to notify the school within 24 hours if my daughter or any member of my immediate household has developed a communicable disease. I agree to notify the school immediately if the disease if life threatening. I agree to pick up my sick or injured daughter in a timely manner when contacted. The above emergency contacts can be called to pick up my daughter if I cannot be reached. Additionally, in an emergency, if I cannot be contacted, the school has my permission to take my daughter to the emergency room of the nearest hospital and I hereby authorize the medical staff to provide treatment, should a physician deem necessary for the well-being of my daughter.

Signature of Parent/Guardian____ **Date**____________________

Health History Form

***Student Name*____ *Date of Birth*_________________________**

***Personal Physician/Healthcare Provider: Name*____**

***Address*____**

Street City State/Zip Code Country

***E-Mail Address*_______________________________________ Telephone #_________________________________**

Personal Medical History (Please mark yes or no if you have or have had any of the following:

Alcohol/Drug Abuse	Yes / No	Hearing Problem	Yes / No
Anxiety/Depression/Mental Illness	Yes / No	Hearing Aid(s)	Yes / No
Asthma	Yes / No	Hemophilia	Yes / No
Bee Sting or Insect Allergy	Yes / No	Hepatitis B Disease	Yes / No
Cancer	Yes / No	High Blood Pressure	Yes / No
Cardiac Condition	Yes / No	Measles	Yes / No
Chicken Pox	Yes / No	Mononucleosis	Yes / No
Convulsions	Yes / No	Mumps	Yes / No
Dental Problems	Yes / No	Pollen	Yes / No
Diabetes	Yes / No	Rheumatic Fever	Yes / No
Dysmenorrheal (Menstrual Cramps)	Yes / No	Sickle Cell Anemia	Yes / No
Endometriosis	Yes / No	Thyroid Disorder	Yes / No
Epilepsy	Yes / No	Tuberculosis	Yes / No
Gastrointestinal Problems	Yes / No	Vision	Yes / No
Head Injury with Loss of Consciousness	Yes / No	Special Diet – List Below	Yes / No

Other: Explain ____

____

Please list below (in English) any medication(s) (including dosage), that you take on a regular basis whether at home or at school. This is all confidential information used for Emergency Personnel as necessary.

Acne	Epi-Pen
Allergy	Headache
Asthma	Pain
Anti-Anxiety/Antidepressants	Seizure
Birth Control Pills	Thyroid
Cardiac	
Insulin (Dosage):	
Other (Specify):	

Allergies: Do you have an allergy or Other Adverse Reactions to any of the following:
If you answer Yes to any, please specify what the allergy is and what to do in case of an emergency.)

Medication **Yes / No**
List Medication:

Food **Yes / No**
List Food:

Insect **Yes / No**
List Insect:

Environmental or Seasonal **Yes / No**
List:

X-Ray Contrast (Dye that is used) **Yes / No**

Any Life threatening Medical **Yes / No**
List:

Consent for Treatment

I grant permission for the Academy of the Holy Family to administer routine medical treatment for my daughter for minor illnesses/injuries and to arrange for any emergency medical care if the circumstances at that time make it impossible for the school to reach me.

Signature of parent/guardian______________________________________ Date______________________