

(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's 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 is 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 \_\_\_\_\_