# Saint Rocco School

*"Sharing the Love of the Heart of Christ!"*

## EMERGENCY MEDICAL INFORMATION 2016-2017

931 Atwood Ave.
Johnston, RI 02919
Tel: (401) 944-2993
Fax: (401) 944-3019
www.stroccoschool.org

Female ____ Male ____

Student Name:_____ Grade____ Date of Birth ___-___-___

Address:_____ Phone:_____

Street City State Zip

**Mother**:
Name:_____
Home Phone:_____
Employer: _____
Work Phone:_____
Cell Phone: _____

**Father**:
Name:_____
Home Phone:_____
Employer: _____
Work Phone:_____
Cell Phone: _____

OTHER CONTACTS: (Please list two (2) persons who are authorized to pick up your child. They must be available during school hours.)

1. _____
   Name Phone # Relationship to Child
2. _____
   Name Phone # Relationship to Child
3. _____
   Name Phone # Relationship to Child

Primary Physician/Pediatrician_____ Physician's Phone_____

Preferred Hospital:_____

Health Insurance:_____

May we contact your doctor if necessary?
_____Yes _____No

**PLEASE COMPLETE THE FOLLOWING:**

**In the event of an emergency, I grant permission for my child to be transported to the hospital: _____Yes ____No**

**I grant permission for my child to be given ( ) Tylenol ( ) Advil ( ) Tums or generic equivalents; per JPS, School Health Services Policies and Procedures and/or School Nurse's discretion.**

_____ _____

**SIGNATURE OF PARENT/GUARDIAN** **DATE**

Unless otherwise directed **in writing,** disclosure of information pertinent to the health of the child listed on this card may be shared with school employees, transportation staff, and/or others who deal in the care of this child.

PLEASE INFORM THE SCHOOL OF ANY INFORMATION CHANGES DURING THE SCHOOL YEAR.

PLEASE COMPLETE OTHER SIDE

# STUDENT HEALTH HISTORY

**Has your child ever had or have any of the following?**

| | NO | YES | YEAR | | NO | YES | YEAR |
|---|---|---|---|---|---|---|---|
| Chicken Pox | | | | Spinal Bifida | | | |
| Measles | | | | Cerebral Palsy | | | |
| Mumps | | | | Downs Syndrome | | | |
| Rubella German Measles | | | | Cystic Fibrosis | | | |
| Pertussis Whooping Cough | | | | Cancer | | | |
| Tuberculosis | | | | Hemophilia | | | |
| Pneumonia | | | | Seizure Disorder | | | |
| Diabetes | | | | Asthma | | | |
| Eczema | | | | Heart Condition | | | |
| Any bone or muscle condition | | | | Kidney Disease | | | |
| Muscular Dystrophy | | | | Anemia | | | |

**Is your child prone to the following?**

| | NO | YES | | NO | YES |
|---|---|---|---|---|---|
| Frequent Headaches | | | Tonsillitis | | |
| Fainting | | | Nose bleeds | | |
| Frequent colds | | | Frequent urination | | |
| Shortness of breath | | | Gastro intestinal upset | | |
| Strep throat | | | Nervous habits | | |
| Ear infections | | | Dizzy Spells | | |
| Hearing problems | | | Other, please explain | | |

If you answered yes to any of the above, please elaborate:_____

_____

Does your child take any medication? Yes _____ No _____

If yes, name the medication and dose _____

Does your child have allergies? Yes _____ No _____

Food _____ Animals, Insects, Chemicals _____ Medication _____ Environment _____

Please explain how your child reacts and the severity of the reaction. (rash, wheezing, etc.)

_____

_____

Does your child require medication for the allergic reaction? Yes_____ No _____

If yes, what is the medication _____

Are there any health problems that would interfere with your child's school activities?

Yes_____ No_____ Explain:_____

Please give any additional health information _____

_____

CHRIST is the reason for this school.
*~in our minds, on our lips, and always in our hearts~*