GRADE: _____

For office only: Tylenol / Ibuprofen YES / NO

Sacred Heart School
EMERGENCY HEALTH DATA SHEET

Mandatory Requirement: Every student must have a complete health data sheet on file in health office.

Student Name: _____ _____ _____
Last First Middle

Date of Birth: ____/____/____ Age: ____ Sex: M____ F____ **Home Phone:** (____) _____ - _____

Race (Please circle or fill in the blank): White Black Hispanic Asian American Indian Other_____

Address: _____ _____ _____
(Street) (City) (Zip Code)

PLEASE PROVIDE INFORMATION FOR THE PARENT/GUARDIAN LIVING WITH CHILD

Who to call first: _____

Father/Guardian Name _____ Home #: _____

Place of Employment: _____ Work #: _____ Cell #: _____

Mother/Guardian Name _____ Home #: _____

Place of Employment: _____ Work #: _____ Cell #: _____

PLEASE LIST PERSONS (OTHER THAN PARENT) WHO MAY CARE FOR CHILD WHO BECOMES ILL AT SCHOOL OR MAY TRANSPORT SICK/INJURED CHILD FROM SCHOOL TO THE DOCTOR IN THE EVENT WE'RE UNABLE TO REACH A PARENT/GUARDIAN.

Name: _____ Relationship: _____ Ph #: _____

Name: _____ Relationship: _____ Ph #: _____

Name: _____ Relationship: _____ Ph #: _____

Child's Physician: _____ Ph #._____

Child's Dentist: _____ Ph #._____

*__Insurance Coverage:__ Does student have medical coverage? Please circle all that apply: **Private MC+/Medicaid NONE**

*__Dental Coverage__: Does your child have a Dentist: Yes ___ No ___ If yes, date of the last exam: _____.

*__Last well child exam:__ Has your child had a well child exam in the last two years: YES / NO

__GRADE 6-12 TYLENOL / IBUPROFEN PERMISSION__: Do you give your permission for the school nurse, or one of the school's qualified staff members, to administer **Acetaminophen (Tylenol)/ Ibuprofen** to your son/daughter as needed for mild pain/discomfort? **PLEASE SIGN BELOW:**

YES_____ NO _____

If your child is allergic to TYLENOL or IBUPROFEN and you DO NOT wish for him/her to receive TYLENOL or IBUPROFEN for pain/discomfort you may provide the school with another form of medication along with signing the "Medication Authorization" Form in the Health Office.

In the event of a medical emergency and the parents/guardians can not be reached, the Sacred Heart School and its authorized personnel will administer emergency first aid (if necessary) and obtain transportation by ambulance to the nearest hospital (if necessary)

Parent/Guardian Signature: _____ Date: _____

PLEASE COMPLETE INFORMATION ON BACK SIDE