Year_____ For Office Use Only: Tylenol/Ibuprofen/Antacid ☐ YES ☐ NO

Sacred Heart School
EMERGENCY HEALTH DATA SHEET

Mandatory Requirement: Every student must have a complete health data sheet on file in the health office COMPLETED EACH NEW SCHOOL YEAR.

Student Name: _____ Date of Birth: _____/_____/_____
Last First Middle

With whom does the child live? ☐ Both parents ☐ Father only ☐ Mother only ☐ Other:_____

Who to call first: _____
Name and Relationship

Father/Guardian Name: _____Cell Phone: _____
Place of Employment: _____ Work Phone: _____

Mother/Guardian Name: _____ Cell Phone: _____
Place of Employment: _____ Work Phone: _____

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

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

****EMERGENCY PERMISSIONS:** In the event of a medical emergency and the parents/guardians can NOT be reached, authorized staff of Sacred Heart School will administer emergency first aid and/or obtain transportation by ambulance to the nearest hospital as deemed necessary.

Parent/Guardian Signature _____

Health Information:
Physician's Name: _____ Phone: _____ Date of Last Visit: _____

Dentist's Name: _____ Phone: _____ Date of Last Visit: _____

Hospital Preference: _____

***Insurance Coverage:**Does the child have medical coverage? ☐ YES ☐ NO Provider/Policy Number_____

***Dental Coverage:** Does the child have dental coverage? ☐ YES ☐ NO If yes, please list:_____

Medication Information:

Please Complete other side ⇨

Student Name:_____ Grade:_____

Does your child take medications? ☐ YES ☐ NO Diagnosis/Reason: _____

Medication	*Dose*	*Time*

****Permission to receive over-the-counter medications: Do you give your permission for the school nurse or office staff to administer medication to your child as needed for mild pain/discomfort?** ☐ YES ☐ NO

Parent/Guardian Signature_____

Please choose which medications are allowed:

☐ Acetaminophen ☐ Ibuprofen ☐ Cough Drops ☐ Tums ☐ Benadryl ☐ Numbing throat spray

FOR 12 & UP ONLY: ☐ Decongestant ☐ Cramp Tab

Health History:

Has your child had or does your child have any of the following diseases or illnesses?

	Age	Date
Chicken Pox……..❑ No ❑ Yes	_____	_____
Fifth's Disease..…..❑ No ❑ Yes	_____	_____
Hepatitis……..❑ No ❑ Yes	_____	_____
Meningitis……..❑ No ❑ Yes	_____	_____
Mononucleosis……❑ No ❑ Yes	_____	_____

	Age	Date
Scarlet Fever……❑ No ❑ Yes	_____	_____
Strep Infection.....❑ No ❑ Yes	_____	_____

Other Contagious Disease....❑ No ❑ Yes- please explain:
_____

- Allergies (foods, medications, environment, animals, etc.) ❑ No ❑ Yes_____
- Asthma……❑ No ❑ Yes
- Dental Problems……...❑ No ❑ Yes
- Diabetes……❑ No ❑ Yes
- Frequent Ear Infections……❑ No ❑ Yes
- Head Injury/Concussion…….. ……❑ No ❑ Yes
- Hearing Problems……❑ No ❑ Yes
- Heart Problems/Murmur……❑ No ❑ Yes
- Mental/Emotional Problems…..……❑ No ❑ Yes
- Physical Limitations……..❑ No ❑ Yes
- Seizure Disorder……...❑ No ❑ Yes
- Speech Problems……..❑ No ❑ Yes
- Tubes in Ears……❑ No ❑ Yes
- Vision Problems……❑ No ❑ Yes

Please explain all "YES" answers here:
_____
_____
_____
_____
_____
_____
_____
_____
_____

**Are there any other health issues that you wish for school personnel to know about? Please explain:_____
_____

Please Complete other side ⇨