

CHRISTIAN BROTHERS ACADEMY

STUDENT HEALTH INFORMATION

So that we have an up-to-date record of all our students each school year, complete this form and return it to CHRISTIAN BROTHERS ACADEMY as soon as possible. All information is held CONFIDENTIAL in the Health Office.

STUDENT NAME _____ BIRTHDATE _____ GRADE _____ DISTRICT _____
 ADDRESS _____ PHONE NO. _____

PARENT/GUARDIAN: (Please state relationship to child) Father _____ Step: Yes () No ()
 Mother _____ Step: Yes () No ()
 Parents (check one): Together (); Separated (); Divorced (); Deceased: Mother (); Father (); Foster ()

PARENTS PLACE OF EMPLOYMENT: (Please note who should be **called first** in an emergency)
 Father _____ Phone # _____
 Mother _____ Phone # _____

In the event your child becomes ill at school and no one can be reached at home or place of business, please provide two emergency contacts:

Emergency Contact #1: _____ Phone _____ Relationship _____
 Address: _____

Emergency Contact #2: _____ Phone _____ Relationship _____
 Address: _____

Family Physician: _____ Phone _____ Physical Exam date _____

Is there anything about your child that you think we should know in order to provide special care?

Has your child had any of the following since the last reporting date (i.e., last school year)?

1. Serious illness, operations: a) _____ Date _____
 b) _____ Date _____
2. Accident or injury requiring a doctor's care: a) _____ Date _____
 b) _____ Date _____
3. Limited Physical activity? - If so, what? a) _____ Date _____
 b) _____ Date _____
4. Vision checkup or hearing exam: a. (vision) Doctor _____ Date _____
 b. (hearing) Doctor _____ Date _____
5. Are medications required at home or school? (Please indicate medication below):
 Medication Name _____ Dosage _____ Time _____
6. Any allergies or handicapping condition? (Please list below):
7. Attending any special clinics – orthopedic, speech, tutoring, hearing, guidance, reading, resource, family counseling or mental health? _____ Date _____

HISTORY – TO BE CHECKED YES OR NO BY PARENTS

	YES	NO		YES	NO
Anemia	_____	_____	Head injuries	_____	_____
Bleeding disorders	_____	_____	Asthma	_____	_____
Diabetes	_____	_____	Allergies	_____	_____
Epilepsy	_____	_____	Ear Conditions	_____	_____
Convulsive disorders	_____	_____	Hearing difficulties	_____	_____
Heart disease	_____	_____	Sight disabilities	_____	_____
Nephritis (kidney disease)	_____	_____	Frequent colds	_____	_____
Pneumonia	_____	_____	Frequent sore throats	_____	_____
Rheumatic Fever	_____	_____	Serious illness	_____	_____
Hernia	_____	_____	Injuries (including fractures)	_____	_____
Hydrocele	_____	_____	Contact with TB	_____	_____
Operations	_____	_____	Hospitalizations	_____	_____

If you have answered "YES" to any of the above items, please give dates and explanations:

PERMISSION IS GRANTED FOR THE RELEASE OF HEALTH INFORMATION TO APPROPRIATE PERSONS ONLY – TEACHERS, COACHES, AMBULANCE PERSONNEL – AND AT THE TIME OF GRADUATION/TRANSFER .

PARENT'S SIGNATURE _____