

**ST. DOMINIC SCHOOL  
CONFIDENTIAL HEALTH RECORD 2009-2010**

Name \_\_\_\_\_ Grade \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_

**Please indicate who should be called first:**

Mother's Name \_\_\_\_\_ Father's Name \_\_\_\_\_

Employer \_\_\_\_\_ Employer \_\_\_\_\_

Employer's Phone # \_\_\_\_\_ Employer Phone \_\_\_\_\_

Pager # \_\_\_\_\_ Pager # \_\_\_\_\_

Cell Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

**Emergency contact if unable to reach parent:**

1) Name \_\_\_\_\_  
Relationship \_\_\_\_\_  
Phone # work \_\_\_\_\_ home \_\_\_\_\_ cell \_\_\_\_\_

2) Name \_\_\_\_\_  
Relationship \_\_\_\_\_  
Phone # work \_\_\_\_\_ home \_\_\_\_\_ cell \_\_\_\_\_

**TO GRANT CONSENT:**

**I hereby give consent for the following medical care providers and local hospital to be called:**

Physician's Name \_\_\_\_\_ Phone # \_\_\_\_\_

Dentist's Name \_\_\_\_\_ Phone # \_\_\_\_\_

Medical Specialist \_\_\_\_\_ Phone # \_\_\_\_\_

Preferred Hospital \_\_\_\_\_ Phone # \_\_\_\_\_

**In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by above-named doctors, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to any hospital reasonably accessible.**

**This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.**

**FACTS CONCERNING THE CHILD'S MEDICAL HISTORY, INCLUDING ALLERGIES, MEDICATIONS BEING TAKEN, AND ANY PHYSICAL IMPAIRMENTS WHICH A PHYSICIAN SHOULD BE ALERTED:**

\_\_\_\_\_

Current Medications – (name, dosage, reason) \_\_\_\_\_

Allergies (food, medicines, etc.) \_\_\_\_\_

Signature of Parent/Guardian \_\_\_\_\_

Address \_\_\_\_\_ Zip \_\_\_\_\_

Date \_\_\_\_\_

**REFUSAL TO CONSENT**

**I do NOT give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take the following action:**

\_\_\_\_\_

**Signature of Parent/Guardian** \_\_\_\_\_

**Address** \_\_\_\_\_ **Zip** \_\_\_\_\_

**Date** \_\_\_\_\_

**If your child needs to take medications at school, please request a “Physician’s Request and Parent’s Request for the Administration of Medication by School Personnel” form from the office.**

List any immunizations this child has received in the past year with date: \_\_\_\_\_

\_\_\_\_\_

Medical History: Has this child had any of the following?

- |   |  |
|---|--|
| <input type="checkbox"/> Chicken Pox                            | <input type="checkbox"/> Vision Problem                |
| <input type="checkbox"/> Frequent Ear infections                | <input type="checkbox"/> severe headaches or migraines |
| <input type="checkbox"/> Hearing difficulty                     | <input type="checkbox"/> Hay fever                     |
| <input type="checkbox"/> Asthma                                 | <input type="checkbox"/> recurrent strep throat        |
| <input type="checkbox"/> Eczema, hives or other skin conditions | <input type="checkbox"/> Seizures or convulsions       |
| <input type="checkbox"/> Diabetes                               | <input type="checkbox"/> Heart problems                |

Hospitalizations – reason and approximate date: \_\_\_\_\_

Operations – please specify \_\_\_\_\_

Serious illness or injury – please specify \_\_\_\_\_

Any other health issues affecting this child’s attendance/performance in school? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
(Parent Signature)

\_\_\_\_\_  
(Date)

**(Please feel free to write additional information on the bottom of this form )**

**This form must be signed and dated in 2 places – either To Grant Consent or Refusal to Consent AND at the end of the form. Thank you**