St. Mary's School - Student Health Information

Dear Parent(s) or Guardian: Please complete the following form which pertains to your child's health. This information will become part of your child's school health record and may be shared with St. Mary's School Staff, Lincoln County Health Department and the rescue squad personnel who are responsible for caring for your child while he/she is attending school, extracurricular activities, or in an emergency situation.

Student Name: _____ Birthday: _____ Grade: _____

Parent(s) or Guardians(s):	Phone Number (Home)	Phone Number (Work/Emergency)
_____	_____	_____
_____	_____	_____

Emergency Contact(s)	Phone Number	Relationship
1. _____	_____	_____
2. _____	_____	_____

Please check if your child has any of the following:

☐ Vision
☐ Hearing Problems
☐ Attention Deficit Disorder
☐ Skin Problems/Rashes
☐ Allergies (list below)
☐ Asthma
☐ Respiratory Problems
☐ Diabetes
☐ Cancer
☐ Stomach/Bowel Problems
☐ Muscle/Joint/Bone Problems
☐ Behavior Problems
☐ Frequent Colds/Sore Throats
☐ Severe Headache
☐ Operation/Hospitalization
☐ Special Health Care Needs
☐ Kidney/Bladder/Urine Problems
☐ Heart Problems
☐ Epilepsy/Seizure Disorders
☐ Serious Accidents or Injuries
☐ Others (please specify) _____

Has your child had chicken pox disease? ☐ Yes, Date _____ ☐ No

Allergic to: _____

Asthmatic ☐ Yes * ☐ No

Signs of an Allergic Reaction include:
☐ Mouth - Itching and swelling of the lips, tongue, or mouth
☐ Throat* - Itching and/or a sense of tightness in the throat, hoarseness, and/or hacking cough
☐ Skin – Hives, itchy rash, and/or swelling about the face or extremities
☐ Gut – Nausea, abdominal cramps, vomiting, and/or diarrhea
☐ Lung* – Shortness of breath, repetitive coughing, and/or wheezing
☐ Heart* – "Thready" pulse, "passing-out"

Please list any additional information in regard to the conditions listed above that would be helpful in caring for your child: _____

If your child takes prescription medication, please list name of medication, dosage and frequency of medication. If your child needs to take prescription medication during school, a prescription medication consent form must be completed and returned to the school. _____

In the event that parents/guardians or emergency contacts are not available, emergency medical services will be contacted if needed.

Parent Signature _____ Date _____

PLEASE NOTE: WE NEED AN UPDATED IMMUNIZATION RECORD ON FILE FOR YOUR CHILD(REN).
If you haven't provided yet, please have your doctor's office fax those records to 715-453-9195. Thank you!