

St. Anthony School 2010--2011

Name _____ Birth date _____
 Grade _____ Teacher _____ School district _____
 Religion _____ Parish/Church _____ Ethnic Background _____

Parents/guardians _____ Home phone _____
 Primary Home address _____ City _____ ZIP _____
 Primary email address _____
 Parents/guardians _____ Phone _____
 Second Home address _____ City _____ ZIP _____
 Secondary email address _____

Parent's employment
 Father _____ Work phone _____ Cell phone _____
 Mother _____ Work phone _____ Cell phone _____
 Emergency contact (other than parent)
 Name _____ Relationship _____ Phone# _____
 Name _____ Relationship _____ Phone # _____
 Does student have: Private health insurance Yes__ No__ Medicaid Yes__ No__ ID# _____

PEOPLE ALLOWED TO PICK UP YOUR CHILD (REN):

Person #1 _____ Phone # _____
 Person #2 _____ Phone # _____
 Person #3 _____ Phone # _____

Names of last school(s) attended
 School _____ City _____ State _____
 School _____ City _____ State _____

Doctor's Name & Number _____ Physical exam within last 2 years? Yes__ No__

 Dentist's Name & Number _____ Dental exam within last 2 years? Yes__ No__

 Is your child under an orthodontist's care? Yes__ No__ Doctor's name _____
 Hospital preference _____

DOES YOUR CHILD HAVE:

ALLERGIES

Allergies No__ Yes__ To drugs, food, insects, pollen? Please list: _____
 Check symptoms that apply: __Difficulty breathing/wheezing __ Swelling of
 face, throat, tongue __Hives or rash __ Abdominal pain __ Other _____
 Bee sting No__ Yes__ Describe reaction: _____
 Allergy Check symptoms that apply: __Difficulty breathing/wheezing __ Swelling of
 face, throat, tongue __Hives or rash __ Abdominal pain __ Other _____
 EPI-PEN JR. 0.15 MG Does your child have an Epi-Pen Jr.? __Yes __No If yes, please see your
 child's school health personnel regarding location of Epi-Pen Jr. while your
 child is in school.
 Above, if you checked difficulty breathing or wheezing, swelling of face, throat or tongue, or hives or rash,
 please consult your child's doctor regarding the possible need for an Epi-Pen Jr. for management of your child's
 allergy.

MEDICAL CONDITIONS

Asthma	No__ Yes__	Triggered by:_____	Medications:_____
		Date diagnosed:_____	MD name:_____
Diabetes	No__ Yes__	Takes insulin: __Yes __No	Date diagnosed:_____ MD name:_____
Epilepsy/ Seizures	No__ Yes__	Describe seizure:_____	
		Date of last seizure:_____	Medications:_____
		MD name:_____	
Heart Condition	No__ Yes__	Describe:_____	
		Any physical restrictions?_____	Medication:_____
Bone/Joint Condition	No__ Yes__	Describe:_____	
		Any physical restrictions?_____	Medication:_____

Other information that will be helpful to us:

Takes daily medications at home? __No __Yes At school? __No __Yes Emergency only? __No __Yes
Name of medication:_____ Dosage:_____ Times taken:_____

Reason for taking:_____

Eyes: Glasses __ (reading __ distance__) contacts__ crossed__ lazy eye__ difficulty seeing __

Ears: Frequent infections__ tubes__ hearing difficult (explain)_____

Wears hearing aid right__ left__

Other concerns:

Nosebleeds__ eating__ sleeping__ bowel__ requires diapering? __No __Yes skin__ bladder__

needs catheterization? __No __Yes bedwetting__ dental__ blood disorder__ neurological__

lungs__ headaches__ menstruation__ phobias (fears) __ ADD/ADHD__ blood pressure__

List any serious illnesses, injuries, or operations _____

Conditions that prevent PE participation _____

SPECIAL SERVICES student receives: OT/PT__ Special diet__

Any special requirements or care necessary _____

Special procedures required _____

Over the Counter (OTC) Medication Permission

I give permission for designated school personnel to use peroxide and/or alcohol, apply topical creams (such as Hydrocortisone cream, antibiotic ointment), acetaminophen, ibuprofen, cough drops, Tums, mints(supplied by parent) and/or basic first aid treatments as appropriate.

Signature of Parent or Legal Guardian _____ Date _____

I give permission for designated school healthcare personnel to obtain information from my child's doctor, _____ MD for emergency purposes, and in order to comply with the State's mandatory immunization requirements for school attendance.

Signature of Parent or Legal Guardian _____ Date _____