

St. Francis School Student/Family Information

Student Name:

Current Grade/Class:

Birth Date:

Student Email Address:

Address (Home Address):

Please list any information you would like to share regarding your child's health, including any medical conditions, drug/food allergies, fears, etc.:

Child uses EpiPen for allergic reaction: _____ **List all medications taken on a regular basis:**

Others authorized to pick up child (Name/Relationship/Phone Number): _____

Emergency Contact Name: _____

Emergency Contact Name: _____

Phone:

Phone:

Physician Name:

Physician Phone:

Hospital Preference:

Insurance Co. & Policy Number:

Parent Name:

Employer:

Occupation:

Employer Address:

Cell:

Business:

Email:

Parent Name:

Employer:

Occupation:

Employer Address:

Cell:

Business:

Email:

St. Francis School has permission to use photographs of my child in school publications, news segments and other forms of media promoting St. Francis School. _____ **(Parent Initials)**

I understand that during the course of the academic year, my student may participate in trips that are hosted off campus. These trips will be under the direct supervision of a St. Francis School faculty member, with occasional additional supervision of parents of students of St. Francis School. I also understand that my student will be transported in a school contracted or designated vehicle. I request that my student be allowed to attend trips as organized by St. Francis School and to use the information provided on this form to contact other caregivers or physicians as needed. I authorize any medical treatment in the case of an emergency, and agree that I am responsible for the cost of such treatment. I understand it is my responsibility to notify St. Francis School of any changes in information on this form or of any change in medical or physical condition of my student that would affect the safety of my student.

Parent's Signature: _____ **Date:** _____

Emergency Health Care Plan

*Place
Child's
Picture
Here*

Student Name: _____

Lead Teacher/Advisor: _____

Allergic to:

Foods _____

Insects _____

Medications _____

Other _____

Please circle symptoms that you know child may exhibit:

Systems:

- Mouth
- Throat
- Skin
- Gut
- Lung
- Heart

Symptoms:

- Itching & swelling of the lips, tongue, or mouth
- Itching and/or a sense of tightness in the throat, hoarseness, and hacking cough
- Hives, itchy rash, and/or swelling about the face or extremities
- Nausea, abdominal cramps, vomiting and/or diarrhea
- Shortness of breath, repetitive coughing, and/or wheezing
- "Thready" pulse, fainting

Action for Minor Reactions:

If symptoms are: _____,

give _____
(medication/dose/route)

Then call:

1. Mother: _____

Father: _____
(name, number)

2. Doctor _____ at _____
(name) (number)

Action for Major Reactions:

If ingestion is suspected and/or symptom(s) are:

Give _____ immediately!
(medication/dose/route)

Then call:

1. EMS--911
2. Mother or Father (above)
3. Doctor (above)

**DO NOT HESITATE TO ADMINISTER MEDICATION OR CALL EMS--911 EVEN IF PARENTS
OR DOCTOR CANNOT BE REACHED!**

Parent Signature

Date