2025-26 St. Paul Catholic High School STUDENT HEALTH Emergency Information

Student Name: _____ Date of Birth: _____ Grade: _____
(Last, First)

Address: _____ Home Phone: _____
(Street, City)

Mother/Guardian: _____

Email: _____ Cell Phone: _____

Employer: _____ Work Phone: _____

Father/Guardian: _____

Email: _____ Cell Phone: _____

Employer: _____ Work Phone: _____

Designated contact person if parent/guardian is unable to be reached during school hours in case of emergency, illness, or injury. This person is authorized to pick up the student from school as needed:

Contact: _____ Relationship: _____ Phone: _____

Contact: _____ Relationship: _____ Phone: _____

Contact: _____ Relationship: _____ Phone: _____

Health Care Provider Name: _____ Phone #_____

Hospital of Choice: _____

Does student have health insurance? Yes___ No ___ If yes, type of insurance: _____

1) Is student taking any medications? Yes___ No___

Name of *medications:* _____

Medication Allergies: _____

2)Food Allergies & Symptoms: _____

Food allergy requires use of EpiPen/Benadryl: Yes___ No___

3)Severe Bee Sting Allergy: *Requires use of EpiPen/Benadryl Yes___ No___*

4)Asthma: Yes___ No___ *If yes: Mild___ Moderate___ Severe___ Exercised Induced___ Date of last episode_____*

Asthma Medication: Yes___ No___

5)Seizures: Yes___ No___ *Date of last Seizure:* _____ *Type:* _____

6)Diabetes: Yes___ No___ *Use of Insulin Pump___ Pen___ Injection___ Other:* _____

7)Other special medical needs/considerations _____

I authorize the exchange of information between the school health office and my child's health care provider. I also authorize the school health office to arrange for medical assistance or transportation to a hospital at my expense if needed. I understand that I must notify the school health office with any changes to the information above.

Parent/Guardian Signature: _____ ***Date:*** _____