2024-25 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:*** ___________