

ST. THERESA SCHOOL EMERGENCY AND MEDICAL FORM (2018-2019)



Name (Last) _____ (First) _____ Birth Date _____

Emergency Contacts

In case of an emergency the parents/guardians will be called first. If unable to be contacted, please provide the names and contact numbers of 2-3 others that would be able to come during school hours. Please ask for assistance if unable to provide any emergency contacts and we will help with possible school families.

Name _____ Relationship _____

Contact Number _____ Cell Phone Home Phone

Name _____ Relationship _____

Contact Number _____ Cell Phone Home Phone

Name _____ Relationship _____

Contact Phone _____ Cell Phone Home Phone

Medical Information

ADHD: _____ Medication: _____

Allergies: _____ Medication: _____

Anxiety: _____ Medication: _____

Asthma: _____ Medication & Dose _____ Student Carry _____

Seizure Disorder _____ Medication: _____

Diabetes (Pump or Injections) _____ Medication: _____

Heart Condition (ANY Restrictions) _____

Orthopedic Problems _____

Stomach /Bladder/Bowel Problems _____ Medications: _____

Vision Glasses Contacts Color Blind Eye Surgeries _____

Hearing Problems _____

Any Other Health Issues / Concerns _____

List all other daily medications taken at home _____

Signature _____ Date _____