All Saints Catholic School
Annual Student Health Card

Last Name _____ First Name _____ D.O.B. _____

Teacher _____ Grade _____ HR _____

Please list your child's chronic health conditions diagnosed by a physician. _____

Please list your child's food, insect, or medication allergies diagnosed by a physician. _____

Has your child been tested for allergies? If yes, date last tested _____ No _____

What kind of reaction does you child have with their allergies (local swelling, hives, anaphylaxis) _____

***Health care required in school cannot be initiated without physician documentation (We may require documentation from a specialist such as an asthma/allergist, neurologist, orthopedist)**

Please list your child's medications (dose and times) _____

***Please contact school nurse when your child needs to take medication during school hours.**

Restrictions: Classroom _____ Physical Education _____
*A doctor's note is required when student is unable to take gym

Vision: Known problem _____ Glasses _____ Contact lenses _____

Hearing: Known problem _____ Hearing Aide R ear _____ L ear _____ Both _____

***Please note: The school nurse has a doctor's order from our school physician to administer Tylenol for pain/fever, Epipen for unknown anaphylaxis, Calamine/Caladryl lotion for itching rashes, insect bites and Antibiotic ointment to minor skin abrasions and lacerations.**
I give permission to the school nurse to administer the medications listed above as ordered by the school physician.

_____ _____
Signature of Parent/Guardian Date

Student Last Name _____ First Name _____
Address _____ Student lives with _____
Mother's Name _____ Home # _____
Work # _____ Cell # _____
Father' Name _____ Home # _____
Work # _____ Cell # _____
Other (Guardian, Stepparent) _____ Address _____
Home# _____ Work # _____ Cell # _____

If parent cannot be reached in an emergency, names of *local* responsible adults to call who may pick up your child:

Name (Relation) _____ Phone # _____
Name (Relation) _____ Phone # _____

Does your child have health insurance? No ____ If yes, name insurance company _____

Does your child have dental insurance? No____ If yes, name insurance company _____

Physician _____ _____ _____
Name Address Telephone #

I authorize the school nurse to communicate with my child's physician regarding their physical/immunization required for school, and health care provided at school. I also give permission to the school nurse to share pertinent medical information with the school staff.
(*Communication is needed to initiate and manage health care at school.)

Signature of Parent/Guardian _____ Date _____