Light of Christ Catholic Schools

STUDENT HEALTH INFORMATION SHEET

(Effective 8/15 - 5/16) School: _____

Student: _____ **DOB:** _____ Grade**/Teacher:** _____

Parent/Guardian: _____ Home: _____ Cell: _____ Work: _____

Emergency Contact (other than parent who can transport or make decisions regarding the student)

1._____ Relationship: _____ Phone: _____

2._____ Relationship: _____ Phone: _____

Hospital/Doctor: _____ Phone: _____

EMERGENCY: Does student have a health problem which could result in an emergency (asthma, insect sting, seizure, diabetes, bleeding problem, heart condition, other etc.)? **Yes** **No**

If YES, please describe: _____

Will your child have an Epi-pen at school? **Yes** **No**

Will your child have a Rescue Inhaler at school? **Yes** **No**

Would you like an Emergency Care Plan on file for your student: **Yes** **No**

Medications taken regularly at home and/or school, and reason: _____

Health History (Circle Yes or No and give additional information as needed)

ALLERGIES **Yes** **No**

Specify_____

ASTHMA **Yes** **No**

Medications_____

ATTENTION DEFICIT **Yes** **No**

Age Diagnosed_____

DIABETES **Yes** **No**

Medications_____

EMOTIONAL CONCERNS **Yes** **No**

Specify_____

HEARING CONCERNS **Yes** **No**

Describe_____

HEART CONCERNS **Yes** **No**

Medications_____

SEIZURES **Yes** **No**

Medications_____

SPECIAL DIET **Yes** **No**

Specify_____

VISION CONCERNS **Yes** **No**

Contacts/Glasses_____

OTHER **Yes** **No**

Specify_____