

*Saint Theresa Catholic School*  
**HEALTH AND EMERGENCY INFORMATION**  
**School Year 2010-2011**

**Student Information** (A separate form is required for each student.)

Student Name: \_\_\_\_\_ Grade/Room: \_\_\_\_\_

Birth date: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_

Who does student live with? Mother / Father / Both / Other (circle one)

If other, please list \_\_\_\_\_

Relationship: Mother

Relationship: Father

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Occupation: \_\_\_\_\_

Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_

Employer: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

**Medical History**

Medical conditions (diabetes, asthma, ADHD etc.) \_\_\_\_\_

List any prescription medications your child takes at home: \_\_\_\_\_

at school: \_\_\_\_\_

*(Please complete and submit a "Permission to Give Prescription Medication" form in the Nurse's Office. Nurse's Office forms can also be found on the school website at [www.stcs.us](http://www.stcs.us).)*

Does your child require use of an inhaler/breathing machine (SVN)? Yes / No

If yes, what time of year does your child have the most difficulty? Fall/Winter/ Spring

Does your child have an allergy that requires use of an EpiPen? Yes / No

If yes, list allergen \_\_\_\_\_

Does your child require corrective lenses? Yes / No      Glasses / Contacts / Both (circle one)

Does your child have diagnosed hearing loss or impairment? Yes / No

Please explain \_\_\_\_\_

**Emergency Information**

Physician Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

Hospital Preference: \_\_\_\_\_

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

Saint Theresa Catholic School  
5001 E. Thomas Road, Phoenix, AZ 85018  
(602)840-0010

## Permission to Pick Up School Year 2010-2011

All information is confidential and will only be used for safety concerns.

Name of Child(ren): (Please use other side if needed.)

Name: \_\_\_\_\_  
Last First MI Grade/Room

Name: \_\_\_\_\_  
Last First MI Grade/Room

Name: \_\_\_\_\_  
Last First MI Grade/Room

Name: \_\_\_\_\_  
Last First MI Grade/Room

**Primary Guardian** (person to be contacted first for any issues)

Name \_\_\_\_\_

Relationship to child \_\_\_\_\_

Contact phone numbers:

Home \_\_\_\_\_ Cell \_\_\_\_\_

Employer Name & Work # \_\_\_\_\_  
\_\_\_\_\_

**Additional Caregiver**

Name \_\_\_\_\_

Relationship to child \_\_\_\_\_

Contact phone numbers:

Home \_\_\_\_\_ Cell \_\_\_\_\_

Employer Name & Work # \_\_\_\_\_  
\_\_\_\_\_

**Additional Caregiver**

Name \_\_\_\_\_

Relationship to child \_\_\_\_\_

Contact phone numbers:

Home \_\_\_\_\_ Cell \_\_\_\_\_

Employer Name & Work # \_\_\_\_\_  
\_\_\_\_\_

**Additional Caregiver**

Name \_\_\_\_\_

Relationship to child \_\_\_\_\_

Contact phone numbers:

Home \_\_\_\_\_ Cell \_\_\_\_\_

Employer Name & Work # \_\_\_\_\_  
\_\_\_\_\_

Any person picking up the child(ren) will be expected to show a picture ID. If the staff has any questions, we reserve the right to contact the primary guardian for verification. **Please notify the school immediately if any of this information changes.**

\_\_\_\_\_  
Signature of Primary Guardian

\_\_\_\_\_  
Date

Name of Child(ren): (Continued from front.)

Name: \_\_\_\_\_  
Last First MI Grade/Room

Name: \_\_\_\_\_  
Last First MI Grade/Room

Name: \_\_\_\_\_  
Last First MI Grade/Room

Name: \_\_\_\_\_  
Last First MI Grade/Room

# SAINT THERESA CATHOLIC SCHOOL

## PERMISSION TO GIVE *PRESCRIPTION* MEDICATION AT SCHOOL

Student Name: \_\_\_\_\_ Grade/Room: \_\_\_\_\_

Medication Allergies: (if none, please write "none") \_\_\_\_\_

Prescription Medication to be given at school: \_\_\_\_\_

Dosage: \_\_\_\_\_ Frequency: \_\_\_\_\_ Route: \_\_\_\_\_

Time(s) to be given at school: \_\_\_\_\_

Dates to be given at school: from \_\_\_\_\_ to \_\_\_\_\_

I am aware of the potential side-effects of this medication, and I hereby authorize the School Nurse or administrative designee to be my agent to give this medication to my child \_\_\_\_\_ as ordered by Dr. \_\_\_\_\_.

I realize that the school does not have to agree to allow medication to be given to a student by school personnel. I understand that the school's agreeing to allow the medication to be given is for my benefit and the student's benefit. Such agreement by the school is adequate consideration of my agreements contained herein. In consideration for the school agreeing to allow the medication to be given to the student as requested herein, I agree to indemnify and hold harmless the Diocese of Phoenix, its servants, agents, and employees, including, but not limited to the parish, the school, the principal, and the individuals giving the medication, of and from any and all claims, demands, or causes of action arising out of or in any way connected with the giving of the medication or failing to give the medication to the student. Further, for said consideration, I, on behalf of myself and the other parent of the student, hereby release and waive any and all claims, demands, or causes of action against the Diocese of Phoenix, its agents, servants, or employees, including, but not limited to the parish, the school, the principal, and the individual giving or failing to give the medication.

\_\_\_\_\_  
Parent/Legal Guardian Signature

\_\_\_\_\_  
Date

***Reminder: All medication must be delivered to the School Nurse or administrative designee by the parent or guardian in an original pharmacy container with the student's name, name of the medication, dosage, frequency and duration of treatment.***

# SAINT THERESA CATHOLIC SCHOOL

## PERMISSION TO GIVE OVER-THE-COUNTER MEDICATION AT SCHOOL

Student Name: \_\_\_\_\_ Grade/Room: \_\_\_\_\_

Medication Allergies: (if none, please write "none") \_\_\_\_\_

Please place a check mark in front of the medications that you are providing and allowing the nurse or principal's designee to administer to your child.

\_\_\_\_\_ acetaminophen (Tylenol)

\_\_\_\_\_ antihistamine (Benedryl)

\_\_\_\_\_ ibuprofen (Advil, Motrin)

\_\_\_\_\_ antibiotic ointment (Neosporin)

\_\_\_\_\_ antacid (Tums, Mylanta)

\_\_\_\_\_ hydrocortisone cream

\_\_\_\_\_ other \_\_\_\_\_

These medications must:

- Be provided and delivered by the parent/guardian
- Be supplied in original container
- Not be expired
- Be supplied in 24 to 50 count bottles  
(due to space constraints, please no large bottles)

Medications will be administered at the nurse's discretion. Dosage will be consistent with the child's weight/age as indicated by the manufacturer's guidelines.

I hereby authorize the School Nurse or administrative designee to be my agent to give the above medication to my child \_\_\_\_\_.

I realize that the school does not have to agree to allow medication to be given to a student by school personnel. I understand that the school's agreeing to allow the medication to be given is for my benefit and the student's benefit. Such agreement by the school is adequate consideration of my agreements contained herein. In consideration for the school agreeing to allow the medication to be given to the student as requested herein, I agree to indemnify and hold harmless the Diocese of Phoenix, its servants, agents, and employees, including, but not limited to the parish, the school, the principal, and the individuals giving the medication, of and from any and all claims, demands, or causes of action arising out of or in any way connected with the giving of the medication or failing to give the medication to the student. Further, for said consideration, I, on behalf of myself and the other parent of the student, hereby release and waive any and all claims, demands, or causes of action against the Diocese of Phoenix, its agents, servants, or employees, including, but not limited to the parish, the school, the principal, and the individual giving or failing to give the medication.

\_\_\_\_\_  
Parent/Legal Guardian Signature

\_\_\_\_\_  
Date