# SETON LASALLE CATHOLIC HIGH SCHOOL

*In Faith and Charity*

## EMERGENCY CONTACT AND HEALTH FORM

Student's Name:______________________________ Grade:_____ Date of Birth:________________

Street Address:________________________________________________________________________

City, State, ZIP:______________________________ Cell/Home Phone:_______________________

Parent/Guardian 1 Name:____________________________ Email:_____________________________

Employer:___________________________________ Position:________________________________

Home Phone:_______________ Cell Phone:_________________ Work Phone:________________

Parent/Guardian 2 Name:____________________________ Email:_____________________________

Employer:___________________________________ Position:________________________________

Home Phone:_______________ Cell Phone:_________________ Work Phone:________________

| Sibling's Name | Date of Birth | School | Grade |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

List names and relationships of all other individuals who reside with student:_________________

______________________________________________________________________________________

Name of School Student Last Attended: _________________________________________________

School Address:________________________________________________________________________

**OVER**

# SETON LASALLE CATHOLIC HIGH SCHOOL

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## EMERGENCY CONTACT AND HEALTH FORM (cont'd)

Name at least THREE relatives or friends to contact when Parent or Guardian is unavailable in the event of a student illness, injury, or emergency. **Please note: Individual must drive and be able to pick up your child during the school day if needed.**

Name:__________________ Relationship: __________ Phone:__________

Name:__________________ Relationship: __________ Phone:__________

Name:__________________ Relationship: __________ Phone:__________

During an emergency, the Emergency Medical Services (EMS-ambulance) will transport your child to **a hospital or facility deemed necessary for the emergency**. Since an emergency can occur at any time, requiring us to call the EMS, it is **VERY IMPORTANT** that the certified school nurse be informed if your child has any of the following: any existing medical or emotional condition(s), a newly diagnosed condition(s), any change in condition, the name of any medication taken regularly at home or that will need to be taken at school.
***For the safety of all students, NO MEDICATION (prescription or non-prescription) is permitted to be carried by the student.**

Doctor's Name:______________ Phone: __________ Date of Last Visit:________

Dentist's Name:______________ Phone: __________ Date of Last Visit:________

Eye Doctor's Name:____________ Phone: __________ Date of Last Visit:________

If your child **does not** have Health, Dental, or Vision Insurance, information is available on free or low cost coverage. Check the information you would like the School Nurse to send you:

☐Health Insurance ☐Dental Insurance ☐Vision Insurance

List **any** medical/emotional conditions your child has:____________________

List **any** allergies:______________ Treatment for allergies:______________

List **any** medication taken regularly at home:____________ Time taken:__________

List **any** medication child is to take in school *(requires a doctor's order–see Authorization for Medication Form)*:______

________________________________ Time to be taken:________

Parent/Guardian Signature:______________________ Date:____________

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## STUDENT HEALTH HISTORY #415-A

**To be completed by the Parent/Guardian. Please check all that apply to your child.**

| | | | | | |
|---|---|---|---|---|---|
| Anxiety | | Developmental Delay | | Nosebleeds | |
| Arthritis | | Diabetes Type 1 | | Orthopedic Condition | |
| Asthma | | Diabetes Type 2 | | Rheumatic Disease | |
| Attention Deficit Disorder | | Dietary Restrictions | | Sickle Cell | |
| Autoimmune Disorder | | Epilepsy/Seizure Disorder | | Speech Difficulty | |
| Bladder/Bowel Control | | Gastrointestinal Condition | | Spina Bifida | |
| Bleeding Disorder | | Hearing Deficit (left/right) | | TB Exposure | |
| Blood Pressure Issues (high/low) | | Immunocompromised | | Thyroid Condition (specify) | |
| Cancer | | Inflammatory Bowel Disease | | Tourette's Syndrome | |
| Cardiovascular Condition (specify) | | Kidney Condition | | Vision: Eye Surgery (specify) | |
| Cerebral Palsy | | Mental Health Diagnosis | | Severe Vision Loss (right/ left) | |
| Chicken Pox (specify date) | | Migraines | | | |
| Color Vision Deficiency | | Neurological Disorder | | | |
| Dental Condition | | | | | |

Explain all above check marks: ____________________________________________

____________________________________________________________

Allergies/Reactions: ____________________________________________

Surgeries/Dates: ____________________________________________

Other: ____________________________________________

**I understand and agree that any and all of this information may be shared with appropriate school personnel.**

Parent/Guardian Signature:______________________________ Date:______________

# SETON LASALLE CATHOLIC HIGH SCHOOL

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## AUTHORIZATION FOR MEDICATION: INFORMATION

For safety reasons, the administration of student medicines–either prescription or non-prescription–is strongly discouraged.

If a Physician deems it necessary for your child to take medications–either prescription or non-prescription–during the school day, the **Authorization for Medication Form** (following page) must be completed by **both** a Parent/Guardian and Physician and returned to the Seton LaSalle Health Office prior to any medication being administered.

The following summarizes the procedure:

- *Physician's orders MUST be completed and dated July 1st or after for the upcoming school year*
- *Prescription medication must be in the current and appropriate labeled pharmacy container. The order and the pharmacy bottle must match*
- *Over-the-counter medication (non-prescription) must be in the original, unopened container and the type of non-prescription medication must match the Physician's orders.*
- *A new form completed by both the Parent/Guardian and Physician is required for each medication, medication change, dosage change, and for each new school year, dated July 1st or after for the upcoming school year*
- *It is the responsibility of your child to report to the Health Office for their medication*
- *Emergency medications (Epinephrine Auto Injector; rescue inhaler and/or Diabetic supplies) may be self-carried and self-administered by students after the completion of the Authorization for Medication Form*

Please remember that your child may not receive their medication if these procedures are not followed. Please feel free to contact the Seton LaSalle Health Office if you have any questions regarding this matter.

Thank you for your cooperation.

In Faith and Charity,
Health Services Department

# Seton LaSalle Catholic High School

*In Faith and Charity*

## AUTHORIZATION FOR MEDICATION FORM #440

Authorization for medication–prescription and non-prescription–to be given during school hours

Student Name:_______________________________________________ Grade: __________

**To be completed by licensed prescriber:**

| | |
|---|---|
| Medication | |
| Dosage | |
| Time of Administration: daily or PRN (how often) | |
| Length of Administration (i.e. duration of school year or a shorter time) | |
| Reason for Medication | |
| Administration Instructions | |
| Side Effects | |
| Self-Administration/Self-Carry (This student is authorized to self-carry their Rescue Inhaler, Auto Injecting Epinephrine and/or Diabetic Supplies and medicate themselves.) | ☐ Yes ________ Physician's Initials<br>☐ No ________ Physician's Initials |

Signature of Licensed Prescriber: ___________________________________ Date: ____________

**To be completed by Parent/Guardian:**

In consideration of Seton LaSalle Catholic High School and Mt. Lebanon School District granting our request to dispense certain medication to our child and/or allow self-administration of medication, the undersigned parents/guardians, on our own behalf and on behalf of our minor child, hereby release, indemnify and hold harmless Mt. Lebanon School District, Seton LaSalle Catholic High School and its Board of Directors, Administrators, Teachers, Secretaries, Nurses and Employees from and against all claims, damages, actions or causes of action resulting and/or arising out of or connected directly or indirectly with the request for or the dispensing of medication listed about to our said child. **I understand and agree to the medical information may be shared with appropriate personnel. I authorize my child's physician to release any medical information that may be required by school or district personnel. I understand and agree that emergency medication may be administered by school employees who are not nurses.**

Parent/Guardian Signature:_______________________________________ Date: ____________