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)

Student Name:_____ Grade:_____

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:_____

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

Parent/Guardian Signature:_____ Date:_____

Name:_____

Grade:_____

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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: _____

List any medical/emotional conditions:_____

Allergies:_____ Treatment for Allergies:_____

Surgeries/Dates: _____

List any medication taken regularly at home:_____ Time:_____

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

Parent/Guardian Signature:_____ Date:_____

Certified School Nurse Signature: _____ Date:_____

1000 McNeilly Road • Mount Lebanon, PA 15226-2593 • Phone: 412-561-3583 • Fax: 412-561-9097 • SLSHS.org

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 and Self-Carry Authorization (found on 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.

Health Services Department

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Name:_____

Grade:_____

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AUTHORIZATION FOR MEDICATION FORM #440

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

Physician Name:_____ Phone Number:_____

To be completed by licensed prescriber:

Medication	
Dosage	
Time of Administration	
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 ☐ 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: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____