ST. THOMAS THE APOSTLE CATHOLIC SCHOOL
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HEALTH HISTORY AND MEDICAL RELEASE

Student's Name _____ Sex _____ Birthdate _____ Grade _____

Parent/Guardian _____ Relation to student _____

Street Address _____ City _____ Zip Code _____

Home Telephone (___)_____ Parent/Guardian Work Telephone (____)_____

HEALTH HISTORY

Family Doctor _____ Telephone Number (____)_____

Preferred Hospital _____

SPECIAL INFORMATION (Please check all that apply. Information will be held in strict confidence.)

Sleep Walking	_____	Fainting	_____	Dizziness	_____
Blackouts	_____	Asthma	_____	Kidney Problems	_____
Frequent Nosebleeds	_____	Frequent Colds	_____	Seizures	_____
Severe Headaches	_____	Homesickness	_____	Diabetes	_____

Other (please explain)_____

ALLERGIC REACTIONS (Please list all known allergies – plant, insect, food, medicine **AND TYPE OF REACTION.)**

_____

_____

Please indicate any other medical problems/situations pertinent to your child:

_____

_____

Any physical limitations? _____ If yes, please explain:_____

_____

Any emotional/physical limitations or reactions to be aware of? _____ If yes, please explain:

_____

_____

What medication, with dosages and frequency, is the student presently taking? (Include those taken at home as well as at school.) _____

_____

_____

Please fill out both sides!

In an EMERGENCY, if we are unable to contact the parent/guardian, we should contact:

1. Name _____ Telephone (___) _____

2. Name _____ Telephone (___) _____

PERMISSION FOR EMERGENCY MEDICAL TREATMENT

In case of emergency, I hereby give permission to transport my child to the nearest hospital/emergency center for emergency medical or surgical treatment. I will be contacted as soon as possible and will be advised prior to any further treatment by the hospital or doctor.

SIGNATURE _____ DATE _____

FAMILY INSURANCE PROVIDER/HEALTH PLAN _____

HEALTH PLAN NUMBER (Include expiration date) _____