

Cardinal Lacroix Academy - Student Health Information Form 2022-2023

Please print

STUDENT: _____ DATE OF BIRTH: ____/____/____ GRADE: _____

Parent/Guardian to Contact 1st

Name: _____ Primary daytime phone: _____

Relationship: _____ 2nd daytime phone: _____

Parent/Guardian to Contact 2nd

Name: _____ Primary daytime phone: _____

Relationship: _____ 2nd daytime phone: _____

Other contacts in the event parents/guardians cannot be reached:

Name: _____ Relationship: _____ Daytime phone: _____

Name: _____ Relationship: _____ Daytime phone: _____

HEALTH INFORMATION

Yes **No** Does your child have any allergies (seasonal, food, insects, medication, latex, etc.)? Please list below.

Allergies _____ How it affects your child _____ Medication given for symptoms _____

Epipen(✓ if yes) _____ Inhalers(✓ if yes) _____

Yes **No** Does your child take any daily medications.? Please list below.

Medication: _____ Dose _____ Times given _____

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Yes **No** Has your child been diagnosed with a chronic disease ? asthma diabetes seizure disorder

Yes **No** Does your child have vision problems? Explain _____
 Wear glasses Contacts (✓ if yes)

Yes **No** Does your child have hearing problems? Explain _____
 Wear hearing aide (✓ if yes)

Yes **No** Had any hospitalization, operation, major illness or injury, or significant accident? Please specify.

Yes **No** Had difficulty with wheezing, excessive coughing or night waking during the last 12 months? Please specify.

Yes **No** Any concerns about your child's general health (overall eating/sleeping, teeth, etc.)? Please specify.

I give permission for the school staff to discuss with other staff members on a "need to know basis" medical issues pertaining to my child. In the event that my child is injured or becomes ill and the school is unable to reach me, I authorize the school to call the physician listed below and to follow his/her instructions. If it is impossible to reach the physician, the school may take whatever arrangements are deemed necessary by the administration.

Doctor _____ Phone _____ Hospital Preference _____

Signature of parent/guardian _____ Date _____

Complete other side of form

CARDINAL LACROIX ACADEMY

PERMISSION FOR GIVING OVER-THE-COUNTER MEDICATIONS

STUDENT _____ GRADE _____

Initial next to the over-the-counter treatments listed below you are allowing Cardinal Lacroix Academy to use on your child during the school year.

- ___ Antibiotic ointment (such as Neosporin) for minor cuts
- ___ Hydrocortisone cream (for insect bites, skin irritation and rashes)
- ___ Ibuprofen children's dose **preferred** (Advil/Motrin) *A parent will be called before administering.*
- ___ Acetaminophen children's dose **preferred** (Tylenol) *A parent will be called before administering.*

Only these medications will be provided by the school. Your child cannot be given any of these medications until this signed form is received.

Your child's teacher will oversee the use of cough drops. Please send them in with a note. Students are never allowed to take ANY medications without supervision.

*In order to administer any **prescription medications** the school must have **Medical Release Forms** (available at www.clanh.org or you may use your physician's form). These must be signed by both the prescribing physician and the parent. The form must include the name of the drug, the dosage, and the time of day the medication is to be taken. Medication must be submitted in their original containers.*

Parent Signature _____ Date _____