CARDINAL LACROIX ACADEMY

EMERGENCY CONTACT AND HEALTH FORM 2025-2026

Student:_____ Grade: _____ Date of Birth: _____

Is this student Latino/Hispanic? YES NO

Student's Ethnicity: __American Indian/Native __Asian __Black __Native Hawaii/Pacific Island __White __Two or more races __Other:_____

Student resides with:

- ☐ Mother only
- ☐ Father only
- ☐ Legal Guardian(s)
- ☐ Both Parents in same household
- ☐ Both Parents in different households
- ☐ Other: _____

Parent to call 1st: _____ Relationship: _____

Daytime Phone#_____ Secondary Phone#: _____

Parent to call 2nd: _____ Relationship: _____

Daytime Phone#_____ Secondary Phone#: _____

Emergency contacts when parents cannot be reached:

Name:	Relationship:	Phone Number:
_____	_____	_____
_____	_____	_____
_____	_____	_____

HEALTH INFORMATION:

Does your child have any allergies (food, seasonal, insects, medication, latex, etc)? YES NO

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

Does your child have asthma? YES NO Does your child use an inhaler? YES NO

Does your child take any daily medications? YES NO

If YES, please list below:

Medication_____ Dose_____ Time given _____

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******Complete other side of form******

Has your child been diagnosed with a chronic disease? YES NO

If yes, please explain: _____

Does your child have vision problems? YES NO

If YES, please explain_____

Does your child wear glasses or contacts? YES NO

Does your child have hearing problems? YES NO

If YES, please explain_____

Does your child wear hearing aide(s)? YES NO

Do you have any concerns about your child's general health? YES NO

If YES, please explain_____

_____

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: _____

PERMISSION FOR GIVING OVER-THE-COUNTER MEDICATIONS:

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

_____ Ibuprofen children's dose (Advil/Motrin) A *parent will be called before administering.*

_____ Acetaminophen children's dose (Tylenol) *A parent will be called before administering.*

_____ Hydrocortisone cream (for insect bites, skin irritation, and rashes)

Your child cannot be given any of these medications until this signed form is received.

*Should your child require **any other over-the-counter medication** not listed above during school hours, parents must provide the medication in its original container with a note stating the name of the medication, the dosage, and the time of day the medication is to be taken. All medications must be kept in the school office. Students are never allowed to take ANY medications without supervision.*

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

Parent Signature_____ Date_____