STUDENT HEALTH INFORMATION

School Year: 2010-2011

Today's Date: ____/___/____

Student Name: ______________________________Student Phone #________________ Birth date: ____ / ____ / ____

Student Address: ____ Healthcare Provider: __________________________

Primary Physician's Name: ____________________________ Primary Physician's Telephone: ____________________

Dentist's Name: _____________________________________ Dentist's Telephone: _____________________________

Insurance Co.: ____________________________ Group #: ___________________ Policy #: ____________________

Please answer ***all*** questions:

Health Concerns	Yes	No	Medication (Name, dosage)	Is monitoring necessary in school?	Comment or Describe
Asthma / Respiratory					
Severe allergies				Food / Latex / Insects / Nuts / Other?	Type & date of last reaction:
Diabetes				Equipment:	
Head injuries					
Seizures / Neurological Migraines					Type & date of last episode:
Emotional / Behavioral (ADHD)					
Heart / Blood					
Muscles / Bones / Joints / Skin					
Bladder / Kidney					
Stomach / Intestines / Bowels					
Immune problems					
Hearing concerns				Hearing aides? Preferential seating?	
Vision concerns				Glasses or contacts? Reading only?	
Growth & nutritional concerns					
Developmental concerns					
Other health concerns					

(continues on back)

1. Routine or daily medications, treatments or therapies (not listed above): ____

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____

2. Activity restrictions in school: ____

____

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3. Special medical equipment required in school? (e.g., oxygen, wheelchair): ________________________________

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4. Have there been any significant changes in your child's health over the last year? Explain: ________________________

____

____

5. List all illnesses, hospitalizations, accidents, and injuries with dates: ____

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Please attach pages for any additional comments or information.

Student lives with: ☐ Both parents ☐ Mother only ☐ Father only ☐ Joint custody ☐ Other____________________

Name	Home Phone	Work Phone	Cell Phone
Mother:			
Father:			
Local Emergency Contact:			

Hospital of Choice: ____

EMERGENCY INFORMATION: Parents are expected to transport their own children from school to home or from school to doctor's office except in cases of dire emergency. In the event of an accident or acute illness, school staff shall attempt to notify the parents first. If the parent or the emergency contacts cannot be reached, the school officials are hereby authorized to take whatever action, including the use of an ambulance, if deemed necessary in their judgment, for the health and safety of the aforesaid student.

CONSENT FOR EMERGENCY TREATMENT: I, the undersigned, hereby authorize officials of Catalyst High School to contact directly the persons named on this card and authorize the named physician or dentist to render such treatment as may be deemed necessary in an emergency for the health of the said student. In the event the named physician or dentist is not available at the time of the student's emergency, I hereby authorize the physician or dentist to whom the student is subsequently referred to render such treatment as may be necessary for the health of said student.

I will not hold Catalyst High School financially or legally responsible for the emergency care and/or transportation for such student.

Your school nurse, **Brenda VonStar**, may be reached at: **303-548-4600** or **vonstar@qadas.com**. Please contact the school nurse directly if you would like to discuss any of the above information that you feel is confidential.

Parent / Guardian Signature: ____

Relationship: ____ **Date:** ___________________________