

# Saint Michael School

## Emergency & Confidential Student Health Update Information Card

PLEASE PRINT LEGIBLY

**Student:** \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Grade/teacher: \_\_\_\_\_ Bus #: \_\_\_\_\_  
**Address:** \_\_\_\_\_ Home phone: \_\_\_\_\_ Locker #: \_\_\_\_\_  
**Mother:** \_\_\_\_\_ Address (if different): \_\_\_\_\_ Phone #: \_\_\_\_\_  
 Place of employment: \_\_\_\_\_ Work #: \_\_\_\_\_ Cell #: \_\_\_\_\_  
**Father:** \_\_\_\_\_ Address (if different): \_\_\_\_\_ Phone #: \_\_\_\_\_  
 Place of employment: \_\_\_\_\_ Work #: \_\_\_\_\_ Cell #: \_\_\_\_\_  
**Guardian:** \_\_\_\_\_ Address (if different): \_\_\_\_\_ Phone #: \_\_\_\_\_  
 Place of employment: \_\_\_\_\_ Work #: \_\_\_\_\_ Cell #: \_\_\_\_\_

List 2 local adults (other than parent/guardian) who will assume immediate care of/ or pick up your child at school if necessary.

Name: \_\_\_\_\_ Address: \_\_\_\_\_ Phone #: \_\_\_\_\_  
 Name: \_\_\_\_\_ Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

\*IF THERE ARE INDIVIDUALS TO WHOM THE SCHOOL SHOULD NOT DISMISS YOUR CHILD, IT SHOULD BE NOTED.

**Student's physician:** \_\_\_\_\_ Phone #: \_\_\_\_\_  
**Student's dentist:** \_\_\_\_\_ Phone #: \_\_\_\_\_  
**Student's orthodontist/other:** \_\_\_\_\_ Phone #: \_\_\_\_\_

In case of an emergency, the school will attempt to contact parent/guardian before calling the student's physician. Your child will be transported with a copy of this card by ambulance to an emergency care facility if necessary. I hereby authorize you to call my physician if I cannot be reached and such a call is considered necessary.

Signature of Parent/guardian: \_\_\_\_\_ Date \_\_\_\_\_

### PLEASE FILL OUT BOTH SIDES

#### CONFIDENTIAL HEALTH INFORMATION UPDATE

During the past year has your child had a physical exam? \_\_\_\_\_ Date: \_\_\_\_\_ Dental exam? \_\_\_\_\_ Date: \_\_\_\_\_

Please circle all current health conditions that apply to your child: ADD/ADHD Anxiety Asthma Depression Diabetes  
 Heart Condition Migraines Seizure Disorders Other (specify): \_\_\_\_\_

List medication/s and dosage taken on a regular basis or as needed: \_\_\_\_\_

**Allergies (specify):** Environmental: \_\_\_\_\_ Food: \_\_\_\_\_  
 Insect: \_\_\_\_\_ Latex: \_\_\_\_\_ Medication/s: \_\_\_\_\_

**Are there any illnesses, injuries, surgery, or additional information that the nursing staff should be aware of since last school year?**  
 No \_\_\_ Yes \_\_\_ (please specify): \_\_\_\_\_

If applicable: Has your daughter started menstruating? \_\_\_\_\_ Any issues/concerns? \_\_\_\_\_

**Vision status (specify):** Normal \_\_\_ Wears glasses \_\_\_ Contacts \_\_\_ All the time \_\_\_ Part time \_\_\_ Distance \_\_\_ Reading \_\_\_  
 Color blindness \_\_\_ Last eye exam \_\_\_ Preferential seating \_\_\_ Any other condition: \_\_\_\_\_

**Hearing conditions (specify):** Left ear \_\_\_ Right ear \_\_\_ **Hearing aids:** Left ear \_\_\_ Right ear \_\_\_ Preferential seating \_\_\_\_\_

**Health Insurance Information:** (If you do not have health insurance, Massachusetts has insurance plans that will provide uninsured children with affordable health care. Please contact the school nurse for more information about these programs. All information will be kept confidential.)

Does your child have health insurance? Yes \_\_\_ No \_\_\_ Company \_\_\_\_\_ Policy # \_\_\_\_\_

Does your child have dental insurance? Yes \_\_\_ No \_\_\_ Company \_\_\_\_\_ Policy # \_\_\_\_\_

**Please initial all that apply:** Please review "Medication Standing Orders" and "Parent Guide to School Health" included  
 My child **MAY** receive medications per physician approved school health protocol by school nurse/designated other as needed.

Please list any specifics you may have: \_\_\_\_\_

My child **MAY NOT** receive medications per physician approved school health protocol by school nurse/designated other as needed.

The school nurse may share my child's relevant health information with appropriate school personnel as needed to meet my child's educational, health, and safety needs. Please list any specific concerns regarding this: \_\_\_\_\_

Signature of Parent/guardian \_\_\_\_\_ Date \_\_\_\_\_

PLEASE MAKE SURE YOU FILL OUT BOTH SIDES

#### CONFIDENTIAL HEALTH INFORMATION UPDATE