St. John Bosco Catholic School
NURSE'S EMERGENCY HEALTH INFORMATION
SCHOOL YEAR 2021-2022

FAMILY NAME (Last):_____ Preferred E-mail: _____

Father's Name: _____ _____ Mother's Name: _____ _____
First Last First Last

Step-Parent Name(s): _____

Home Address: _____, _____ AZ _____
Street Address City Zip

Phone Numbers: (____)_____ (____)_____ (____)_____
Home Father's Cell Mother's Cell

(____)_____ (____)_____ (____)_____
Other: Father @ work Mother @ work

Additional Emergency Contacts must be listed in RenWeb. Students will only be released to those designated in RenWeb.

Child/children **MAY NOT** be released to: _____ (Court orders must be on file with school)

How does your child/children arrive at SJB? Car Walk Bus Bike Carpool with: _____
(circle one) (Family name)

Health Care Providers

Family Doctor/Pediatrician: _____ Phone: (____)_____

Family Dentist: _____ Phone: (____)_____

Specialist: _____ Phone: (____)_____

Specialist: _____ Phone: (____)_____

Parent Consent for Medication Administration, Release of Medical Information and Emergency Treatment

☐ I authorize the school nurse to administer over-the-counter medication per package dosage and schedule recommendations. **Over-the-counter medications are supplied, by me, for my child and are delineated on the back of this form.**

☐ I authorize the school nurse to administer prescribed medication when ordered. **I will supply medication in the original container with a pharmacy issued label and accompanied with a physician's order.**

☐ I permit medical information to be shared as appropriate, with involved school staff, faculty and coaches.

☐ I permit the school nurse, or principal designee, to care for my child/children if illness occurs during the school year. I authorize the School Nurse, or principal designee, to obtain emergency treatment for my child/children if unable to contact a parent/legal guardian.

☐ I permit the school nurse to contact my child/children's health care provider for medical direction, immunizations and information updates.

_____ _____ _____
Signature Relationship Date

***Please complete reverse** ⟹

#1 Student Name: _____ **Date of Birth:**_____ **Room #:**_____

PAST MEDICAL HISTORY (Please check all that apply):

Life Threatening Allergy		Fractures/Bone Disease		Head Injury	
Asthma		Skin Disorders/Eczema		Glasses/Contacts	
Diabetes		Migraine Headaches		Braces/Retainers	
Epilepsy/Seizure Disorder		Recurrent Ear Infections		Hearing Aids	
Heart Disorders/Murmur		Fainting		Other:	

Please explain any condition noted above: _____

_____

Food/Drug Allergies:_____

Medications currently being taken: (for more medications, attach additional sheet):

Med #1:_____Dose/Time:_____Reason:_____

Med #2:_____Dose/Time:_____Reason:_____

Please check which medications your child may receive (medication must be supplied for student):

Acetaminophen (i.e. Tylenol)		External ointments, sprays		Wound washes	
Ibuprofen (i.e. Motrin)		Cough drops/lozenges		Diphenhydramine (i.e. Benadryl)	
Antacids (i.e. Tums, child strength)		Sterile eye drops			

#2 Student Name: _____ **Date of Birth:**_____ **Room #:**_____

PAST MEDICAL HISTORY (Please check all that apply):

Life Threatening Allergy		Fractures/Bone Disease		Head Injury	
Asthma		Skin Disorders/Eczema		Glasses/Contacts	
Diabetes		Migraine Headaches		Braces/Retainers	
Epilepsy/Seizure Disorder		Recurrent Ear Infections		Hearing Aids	
Heart Disorders/Murmur		Fainting		Other:	

Please explain any condition noted above: _____

_____

Food/Drug Allergies:_____

Medications currently being taken: (for more medications, attach additional sheet):

Med #1:_____Dose/Time:_____Reason:_____

Med #2:_____Dose/Time:_____Reason:_____

Please check which medications your child may receive (medication must be supplied for student):

Acetaminophen (i.e. Tylenol)		External ointments, sprays		Wound washes	
Ibuprofen (i.e. Motrin)		Cough drops/lozenges		Diphenhydramine (i.e. Benadryl)	
Antacids (i.e. Tums, child strength)		Sterile eye drops			