PLEASE PRINT CLEARLY

Bishop Larkin Catholic School
Emergency Medical Form

The following information will be shared with the teachers involved with your student and will be considered confidential. It is important that we know all the needs of your children so that we can serve them well. Please fill in the lower portion (one per student) and return to the office by: **Monday, August 14, 2017.**

STUDENT'S NAME:_____
Last **First** **M.I.**

HOME ADDRESS:_____ **PHONE NUMBER:**_____
BIRTHDATE:_____ **AGE:**_____ **SEX:**_____ **GRADE:**_____

FATHER'S NAME:_____ CELL NUMBER:_____
MOTHER'S NAME:_____ CELL NUMBER:_____
(IN CASE OF DIVORCE/SEPARATION) CUSTODY: Mother_____ Father_____ Shared_____
Emergency names/numbers designated by other custodial parent:_____

IF NOT AVAILABLE IN AN EMERGENCY NOTIFY:

1. Name:_____ Phone Number:_____
   Relationship:_____
2. Name:_____ Phone Number:_____
   Relationship:_____

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HAS YOUR CHILD EVER HAD OR HAVE NOW:

	YES	NO		YES	NO
Any joint or bone problem			Blood Disorder		
Heart disease or malformation			Blood transfusion		
Nervous disorders			Epilepsy/Seizures		
Any chronic infections			Vision/hearing disorder		
Diabetes or low blood sugar			Hemophilia		
Chronic skin disease			Wears glasses/contacts		
Allergies			Chicken pox		
Surgeries/Hospitalizations			Chicken pox vaccine		
Requires use of restroom frequently			Date of vaccine		

PLEASE EXPLAIN ANY "YES" ANSWERS:_____

IS YOUR CHILD UNDER TREATMENT OF ANY KIND?_____ Please Explain:_____

IS YOUR CHILD ON MEDICATION?_____ Please Explain:_____

List any health problems or conditions of which the school should be aware:_____

Does your child's condition impact his/her learning? Yes_____ No_____

According to state guidelines, school personnel may not distribute non-prescription medicine for any reason

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_____
Father's Signature

_____
Guardian/Stepparent Signature

_____
Mother's Signature