

Holy Spirit Catholic School Medical Emergency Information

Family Name: _____
Physician's Name: _____ Phone: _____
Hospital of Choice: _____
Dentist's Name: _____ Phone: _____

Please complete the sections below for all your children who attend Holy Spirit.
The medical information you provide is strictly confidential.

Medical conditions (indicate by letter):

- A- Frequent headaches
- B- Frequent sinus infections/hay fever
- C- Asthma
- D- Heart condition
- E- Diabetes
- F- Kidney/Urinary problems
- G- Severe bee sting reaction
- H- Scoliosis
- I- Seizures
- J- Ear or hearing problems
- K- Heat Sensitivity
- L- Food Allergies
- M- Allergies
- N- Other _____

Child's name / Age / Allergies / Daily Meds / Medical Conditions

Students with severe allergies and asthma will need to have an allergy/asthma health care plan on file in the office. Students with other chronic diseases may also need to have a health care plan on file.

Indicate any severe injuries, hospitalizations or surgeries we should know about.

(Please note which child and month and year)

Indicate any other information about your child that is relevant to your child's health at school.

Parent signature _____

Last Name of Student(s)

Parent's Names: _____
Home Phone: _____
Work Phone (Mom): _____
Work Phone (Dad): _____
Cell Phone (Mom): _____
Cell Phone (Dad): _____

Indicate above which parent (and phone number) to call first in case of emergency.

If parents cannot be reached, emergency contact: _____
Relationship to student: _____
Their Home phone: _____ Cell phone: _____ Work phone: _____

Mother's/Guardian's e-mail address: _____
Father's e-mail address: _____
Home address: _____
City/State/Zip: _____

Mother's Employer: _____
Father's Employer: _____

Child/Children live(s) with:
___ both parents ___ father ___ mother ___ grandparent ___ guardian ___ other

Child's Name / Grade / Date of Birth

Adults permitted to take student(s) from school (other than parents):

Name, phone number, and relationship to student:

