Holy Name Catholic School Health History

Child's Name_____ Grade:_____ School Year:_____

Specify any medical, mental, handicap or frequent health issues including the diagnosis:

_____

_____

List any serious food, drug or other allergies:_____

Has your child been prescribed EpiPen or Benadryl for emergency treatment of this allergy? _____

Is your child currently being treated for asthma?____ uses inhaler____ daily____ often___ never_____

Do you give permission for this health information to be shared with your child's teachers?_____

Do you give permission for the school to contact your child's physician, if necessary?_____

Name of family physician: _____ Phone:_____

Emergency Contact (other than parent or guardian):_____

Relationship:_____ Telephone: _____

If illness or injury occurs, I authorize staff of Holy Name Catholic School, on my behalf, to necessitate treatment by a qualified health care provider(s) in the event I cannot be reached.

Parent/GuardianSignature:_____ Date:_____

Authorization to administer Prescription and Over the Counter Medication

All other over the counter medications must be supplied by the parent or guardian. Circle each medicine that you give permission for your child to receive, and CROSS OUT any that should not be given.

Acetaminophen (generic Tylenol)	Ibuprofen (generic Advil)	Cough drops/chloroseptic spray
Anti-itch creams and Benadryl	Antibiotic ointments	Antacids
Medicines taken on a regular basis		Other_____

Prescription medication: _____ Dr.'s signature_____

I give permission for individuals designated by the principal to administer the medications that are circled. By signing this form, I agree to hold harmless and indemnify Holy Name Catholic School and any staff member for any and all losses that may be occasioned as a result of taking this medication, including adverse reactions.

Date:_____ Authorized Signature: _____