St. James CCD
2020 Health Form

TO BE COMPLETED ANNUALLY FOR EACH CHILD AND RETURNED WITH REGISTRATION FORMS

Child's Name____

Address____

City, Zip Code____

Phone with area code__________________Birth Date___________Grade_____

Father's Name_________________________Phone/area code______________

Mother's Name________________________ Phone/areacode______________

Neighbors/Relative to contact in case of emergency:

1. Name______________________________Phone/area code_____________
2. Name______________________________Phone/area code_____________

PARENT PERMISSION TO PROVIDE EMERGENCY PHYSICIAN AND HOSPITAL TREATMENT:

If neither parent can be reached, you may have my permission to call Dr.________________ at _(_____)______________. If unable to contact parents or family physician, you have my permission to transport my child to the nearest medical facility or Palos Community Hospital. We agree to assume all responsibility and expenses, including transportation, incurred by the handling of this emergency case.

YES_________ NO___________

DATE_____________Parent's Signature_____________________________

CURRENT HEALTH STATUS

Check any that apply. Give explanation if necessary.

Allergies____ Type of allergy____
Asthma____
Diabetes____
Epilepsy/Seizure Disorder____
Headaches____
Heart Condition____
Orthopedic/Physical Limitations_______________________________________
Dental Problems_____________________Wears braces?__________________
Digestive Problems____
Hearing Problems____________Type of problem_________________________
Wears Glasses?________________Wears contacts?______________________
Takes medication?____________Type of medication______________________
Reason for Medication____
Recent serious illness, injury or other health problem:______________________
Any other problems we should be aware of:_____________________________

All above information is current and correct:
Parent's Signature_____________________________Date________________