2021-2022
Queen of the Holy Rosary Wea
Health History & Permit to Release Information

Emergency Consent
(To be released only on signature of parent/guardian)

Statement of Consent I authorize school personnel to obtain emergency medical care for my student in the event I cannot be reached. If transportation by ambulance is required, this may be obtained. In addition, all the information provided below is accurate to the best of my knowledge **and may be shared on a need to know basis with select personnel when my child's health and well being require knowledge of a health concern.**

X_____ ***MUST BE SIGNED TO TREAT FOR EMERGENCY!!**
Parent/Guardian signature /Date

Name: _____ **DOB:** _____ **Grade:**_____

Health insurance: No ____ Yes ____

Contacts (this information is helpful when a referral for services is in question)**:**

_____(_____)_____/ _____
Physician Name and Phone **Hospital Preference**

_____(_____)_____/ _____(_____)_____
Dentist Name and Phone # **Orthodontist Name and Phone #**

Health Conditions (check all that apply and comment below)

- ☐ *Allergies/Seasonal**
- ☐ *Allergies/Potentially Life Threatening**
- ☐ *Asthma**
- ☐ *Anxiety (frequent)*
- ☐ *Attention Deficit Disorder Medication prescribed*
- ☐ *Blood Disorder*
- ☐ *Car sickness (that would affect a field trip)*
- ☐ *Celiac Disease*
- ☐ *Congenital Heart Disease*
- ☐ *Diabetes*
- ☐ *Ear Infections (frequent)*
- ☐ *Glasses/contacts*
- ☐ *Headaches (frequent)*
- ☐ *Hearing Impairment*
- ☐ *Kidney Disease*
- ☐ *Lactose intolerance*
- ☐ *Seizure Disorder/Epilepsy*
- ☐ *Seizure/History of Febrile Seizure(s)*
- ☐ *Stomach aches (frequent)*
- ☐ *Recent Surgery*_____
- ☐ *Throat Infections (frequent)*
- ☐ *Urinary Tract Infections (frequent)*
- ☐ ***Other health concerns may be listed on the bottom of this form***

*Asthma and Allergies Describe all foods, medications and/or environmental causes that may trigger asthma or allergy symptoms:

- ☐ Food Allergy (history of hives, wheezing, facial swelling or tests positive for food allergy) to_____
- ☐ Insect Sting Allergy (anaphylaxis)
- ☐ Allergy to medication(s), latex, chemicals or food additives (please list)_____
- ☐ Asthma/allergy triggers_____(cold air, viral cold symptoms, animal danger, dust mites etc.)
- ☐ Seasonal allergies: Fall Winter Spring (please circle) List treatment:_____

☐ **PRESCRIPTION medication my child takes at home (*include DOSAGE & FREQUENCY)**

_____

_____

***Please list any special concerns that pertain to your child's health:**

_____ **(USE BACK OF FORM IF NEEDED)**

X_____
Parent Signature/date