**Please completely fill out 1 per student**



SAINT ANN CATHOLIC SCHOOL

## Contact information

Student Name: _____

Date of Birth: _____ Age: _____ Sex: M or F

Child's Primary Address: _____

_____

**Custody** Both Mother Father Other: **(Please List)** _____
**(circle one)**

**Mother's Legal Name/Legal Guardian 1:** _____ **Address same as above:** Y or N

Cell #: _____ Work #: _____ Employer: _____

Home Address: _____ Work Address: _____
(if different)

_____ _____

**Father's Legal Name/Legal Guardian 2:** _____ **Address same as above:** Y or N

Cell #: _____ Work #: _____ Employer: _____

Home Address: _____ Work Address: _____
(if different)

_____ _____

## If a parent or guardian cannot be reached in an emergency, then please notify:

Name: _____ Relationship: _____

Cell #: _____ Work#: _____

Home Address: _____ Work Address: _____

_____ _____

Name: _____ Relationship: _____

Cell #: _____ Work#: _____

Home Address: _____ Work Address: _____

_____ _____

Continue to pg.2

## Health History

List any pre-exsisting or present medical conditions: _____

List name and dosage of any medication taken on a regular basis: _____

List any allergies to **medication**: _____

List any other allergies: _____

Please specify if the student is under any special medical treatment or diet: _____

Any activity restrictions? No or Yes (Circle One) **If yes, please list:** _____

Date of last tetanus Shot: _____ Wears contact lenses: Yes or No (Circle One)

Check if any of the following conditions are present:

| | |
|---|---|
| _____ Hay fever | _____ Heart condtion |
| _____ Allergic to insects | _____ Diabetes |
| _____ Frequent stomach upset | _____ Asthma |
| _____ Epilepsy/nervous disorder | _____ Any major illness/surgery in the past |
| _____ Hearing/vision loss | _____ Food allergies |

If any of the above are checked, please give details: _____

Doctor: _____

Phone #: _____

Address: _____

In the case of a medical or surgical emergency, I hereby give permission to the physician selected by St. Ann Catholic School or its representative to hospitalize and/or secure proper medical treatment for the above named student. I understand that I am responsible for the cost of any medical treatments, including surgery, received by my child. I understand that I will be contated immediately in the case of a health emergency involving my child.

Signature: _____ Date: _____

Insurance Company: _____ Phone #: _____

Policy #: _____ Group #: _____