ST. MALACHY CATHOLIC SCHOOL

CONFIDENTIAL MEDICAL INFORMATION

This form may be used at school in the event of a medical emergency to provide the appropriate school staff with necessary medical information to ensure the health and safety of your child. If necessary, this form would be given to appropriate medical emergency personnel if your child should be transported to a hospital. Please keep this information current throughout the school year.

Name: _____ **Sex:** _____

Grade: _____ **Birth Date:** _____

Parent/Guardian Phone Numbers: (please fill in categories)

Home: _____

Mom (work): _____ **Mom (cell):** _____

Dad (work): _____ **Dad (cell):** _____

Family Physician: _____ **Phone Number:** _____

Allergies: _____

_____

Please list any medications, treatments, or medical care your child receives on a regular basis that medical personnel may need to know at the time of treatment for illness or injury. Please include name and dosage of medication taken daily at home.

_____

_____

_____

_____

(Continued on back)

7410 North Country Road 1000 East | Brownsburg, IN 46112 | 317.852.2242 PH | 317.852.3604 FAX

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Does your child have: (please circle yes or no)

Asthma: Yes No Diabetes: Yes No

Heart Problems: Yes No Subject to seizures: Yes No

Postural Problems: Yes No Physical Handicap: Yes No

Emotional Problems: Yes No Vision Difficulties: Yes No

Wear Glass or Contacts: Yes No—circle which one

Did your child have surgery for the any of the following: (please circle yes or no)

Appendectomy: Yes No Ear Tubes: Yes No

Hernia: Yes No Tonsillectomy/Adenoidectomy: Yes No

If you circled YES to any of the above or have any health problems or surgeries not mentioned, please explain.

_____

_____

_____

_____

_____

If necessary, which hospital would you prefer for your child's treatment?

_____

_____

CONSENT TO MEDICAL TREATMENT FOR MINOR CHILD

I understand that in the case of a serious medical emergency, unless the injury/illness appears to be immediately life-threatening, the staff will make reasonable attempts to contact/me us before authorizing medical treatment. If I /we are not available to give consent, I/we hereby authorize the staff of St. Malachy Catholic School to act on my/our behalf, to call 911 emergency services, transport by ambulance, hospitalize, and secure proper treatment for my child as deemed necessary by qualified medical personnel. I/we also understand that the medical treatment will be shared on a medical "need-to-know" basis among staff and medical personnel.

Notice is hereby given to qualified medical personnel that this authorization is currently in effect, and such personnel are directed to act upon this authorization for the 2018-2019 school year.

Parent/Guardian SIGNATURE(S)_____

DATE_____

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