

# Cardinal Lacroix Academy - Student Health Information Form 2024-2025

Please print

STUDENT: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_ GRADE: \_\_\_\_

## Parent/Guardian to Contact 1st

Name: \_\_\_\_\_ Primary daytime phone: \_\_\_\_\_

Relationship: \_\_\_\_\_ 2<sup>nd</sup> daytime phone: \_\_\_\_\_

## Parent/Guardian to Contact 2nd

Name: \_\_\_\_\_ Primary daytime phone: \_\_\_\_\_

Relationship: \_\_\_\_\_ 2<sup>nd</sup> daytime phone: \_\_\_\_\_

## Other contacts in the event parents/guardians cannot be reached:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Daytime phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Daytime phone: \_\_\_\_\_

## HEALTH INFORMATION

**Yes**  **No** Does your child have any allergies (seasonal, food, insects, medication, latex, etc.)? Please list below.

Allergies	How it affects your child	Medication given for symptoms
_____	_____	_____
_____	_____	_____

Epipen(√ if yes) \_\_\_\_\_  Inhalers(√ if yes) \_\_\_\_\_

**Yes**  **No** Does your child take any daily medications.? Please list below.

Medication: \_\_\_\_\_ Dose \_\_\_\_\_ Times given \_\_\_\_\_

Medication: \_\_\_\_\_ Dose \_\_\_\_\_ Times given \_\_\_\_\_

**Yes**  **No** Has your child been diagnosed with a chronic disease?  asthma  diabetes  seizure disorder

**Yes**  **No** Does your child have vision problems? Explain \_\_\_\_\_

Wear glasses  Contacts (√ if yes)

**Yes**  **No** Does your child have hearing problems? Explain \_\_\_\_\_

Wear hearing aide (√ if yes)

**Yes**  **No** Had any hospitalization, operation, major illness or injury, or significant accident? Please specify.

**Yes**  **No** Had difficulty with wheezing, excessive coughing or night waking during the last 12 months? Please specify. \_\_\_\_\_

**Yes**  **No** Any concerns about your child's general health (overall eating/sleeping, teeth, etc.)? Please specify. \_\_\_\_\_

*I give permission for the school staff to discuss with other staff members on a "need to know basis" medical issues pertaining to my child. In the event that my child is injured or becomes ill and the school is unable to reach me, I authorize the school to call the physician listed below and to follow his/her instructions. If it is impossible to reach the physician, the school may take whatever arrangements are deemed necessary by the administration.*

Doctor \_\_\_\_\_ Phone \_\_\_\_\_ Hospital Preference \_\_\_\_\_

Signature of parent/guardian \_\_\_\_\_ Date \_\_\_\_\_

\*\*\*\*Complete other side of form\*\*\*\*

**CARDINAL LACROIX ACADEMY**

**PERMISSION FOR GIVING OVER-THE-COUNTER MEDICATIONS**

**STUDENT** \_\_\_\_\_ **GRADE** \_\_\_\_\_

**Initial** next to the over-the-counter treatments listed below you are allowing Cardinal Lacroix Academy to use on your child during the school year.

- \_\_\_ Antibiotic ointment (such as Neosporin) for minor cuts
- \_\_\_ Hydrocortisone cream (for insect bites, skin irritation and rashes)
- \_\_\_ Ibuprofen children's dose **preferred** (Advil/Motrin) *A parent will be called before administering.*
- \_\_\_ Acetaminophen children's dose **preferred** (Tylenol) *A parent will be called before administering.*

**Only these medications will be provided by the school. Your child cannot be given any of these medications until this signed form is received.**

Your child's teacher will oversee the use of cough drops. Please send them in with a note. Students are never allowed to take ANY medications without supervision.

*In order to administer any **prescription medications** the school must have **Medical Release Forms** (available at [www.clanh.org](http://www.clanh.org) or you may use your physician's form). These must be signed by both the prescribing physician and the parent. The form must include the name of the drug, the dosage, and the time of day the medication is to be taken. Medication must be submitted in their original containers.*

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_