Cardinal Lacroix Academy - Student Health Information Form 2023-2024

Please print

STUDENT:____________________________________**DATE OF BIRTH:** ____/____/____**GRADE:**______

Parent/Guardian to Contact 1st

Name:____________________________________Primary daytime phone:__________________

Relationship: ________________________________ 2nd daytime phone:__________________

Parent/Guardian to Contact 2nd

Name:____________________________________Primary daytime phone:__________________

Relationship: ________________________________ 2nd 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_______________

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☐ **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.

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☐ **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.

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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 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___________________