

St. Vincent Pallotti High School

Student Emergency Contact Information

STUDENT INFORMATION

Last		First	Middle
Gender <input type="checkbox"/> M <input type="checkbox"/> F	Grade	Cell Phone	Birth Date
Home Address		City	State Zip
Mailing Address		City	State Zip
Student lives with			
Additional Student Names (Please list any additional student(s) you currently have enrolled in Pallotti)			

PRIMARY PARENT/GUARDIAN

The Primary/Guardian is who the student lives with and is the primary point of contact.

Last	First	Relationship to Student	
Home Address (if different from above)	City	State	Zip
Employer	Work Phone	Home Phone	Cell Phone
Is there a court order on file that prevents a parent having contact with the student? <input type="checkbox"/> Yes (Please contact the school to let them know) <input type="checkbox"/> No		Email	

OTHER PARENT/GUARDIAN

Last	First	Relationship to Student	Email
Home Address (if different from above)	City	State	Zip
Employer	Work Phone	Home Phone	Cell Phone
Select info you would like for this contact to receive: <input type="checkbox"/> Data Base (lunch acct. info) <input type="checkbox"/> Attendance <input type="checkbox"/> Report Card <input type="checkbox"/> Scheduling <input type="checkbox"/> Discipline <input type="checkbox"/> Billing <input type="checkbox"/> Advancement (school events)			

PARENT/GUARDIAN AUTHORIZED RELEASE CONTACTS

Please list the names of persons to whom we may release your child to or whom we may contact if we cannot reach the primary or other parent/guardian listed above.

NO STUDENT WILL BE RELEASED TO ANYONE OTHER THAN THE PERSONS LISTED BELOW.

Name	Relationship	Home Number	Work/Cell Number

I/We hereby authorize contact with release of emergency related information, or release of the student to the following person(s) in the event of illness, evacuation, or other emergencies that may occur while the student(s) is in school. I declare that the information on this care is true and correct. I will notify the school of any changes.

Signature:	Date:
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St. Vincent Pallotti High School

Student Medical Information

The personal information you provide on this form will be kept confidential (in protected areas) and only used and disclosed by school staff on a need-to-know basis.

STUDENT INFORMATION

<p>Does your child need to take medication at school?</p> <p style="text-align: center;"><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>If your child requires medication at school, all medication sent to the school must be in original container with the current date and the child's name. Also, a medication/treatment authorization form must be completed and signed by the physician, parent, and must be on file at the school. These forms can be found on our school website.</p>	
<p>Attending Physician</p>	<p>Address</p>	<p>Phone Number</p>

OVER-THE-COUNTER MEDICATION

If you would like your student to take over-the-counter medication during school hours, please complete this section. OTC Medications will be administered according to the manufacturer's recommendation dosage. Please check the medications below that you are giving permission for your student to take while at school.

- Ibuprofen (Advil)
- Acetaminophen (Tylenol)
- Antihistamine (Benadryl)
- Cough Drops
- Tums

MEDICAL CONDITION

Does your child have a medical condition? Check all that apply.

<input type="checkbox"/> Asthma	If checked, does the student use an inhaler?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Seizures	If checked, is the student on medication?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Diabetic	If checked, is the student insulin dependent?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Recent Illness/Hospitalizations/Surgery?

Other _____

Severe Allergies (please specify)

Food (please list food allergy) _____

Medication

Environmental

Insect/Bee Sting

Other _____

If any allergy is checked above, please indicate what action should be taken.

Epi Pen

Benadryl

Other _____

RELEASE OF MEDICAL INFORMATION

I hereby authorize for my child's medical information, parental contact information, and other health information to be shared with emergency personnel in order to address a health or safety emergency.

Parent Signature _____ Date _____