

St Joseph Catholic School Health Room Record

2025-2026 School Year



Family Last Name _____

Address _____ City: _____ Zip _____

Child Living with: Both Parents _____ Father Only _____ Mother Only _____ Guardian (name) _____

Mother's Name _____ Cell Phone _____

Father's Name _____ Cell Phone _____

Mother's Work # _____ Father's Work # _____

Home Phone _____

Emergency contacts: Please list in order of preference, including parents as choice:

1. Name _____ Relationship to Child _____

Cell Phone _____ Home or Work phone _____

2. Name _____ Relationship to Child _____

Cell Phone _____ Home or Work Phone _____

3. Name _____ Relationship to child _____

Cell Phone _____ Home or Work Phone _____

Emergency Hospital of Choice: _____

Does your child (ren) have any medical condition (allergies, dietary restrictions, asthma, diabetes, seizures)? If yes, please explain (include child's name):
