OUR LADY OF PEACE PARISH
Religious Education Programs
2018-2019 HEALTH FORM

STUDENT'S NAME ____

DATE OF BIRTH ________________ **SEX** ______________ **AGE** _________

PARENT(S)/GUARDIAN(S) ______________________________________

HOME ADDRESS ____

HOME PHONE _____________ **PARENT(S) WORK PHONE** ________________

PARENT(S) CELL PHONE ________ **EMAIL ADDRESS** ____________________

EMERGENCY CONTACT: *(Designated person to make decisions if parent/guardians is unavailable)*

NAME _______________________ **RELATIONSHIP** __________________

HOME PHONE ___________________ **WORK PHONE** __________________

HEALTH HISTORY: *Check and explain below. If there has been a serious medical occurrence within the last two years, include any recommendations or restrictions suggested by the attending health care provider.*

__ Asthma
__ Chicken Pox
__ Diabetes
__ Ear disease
__ ADD/ADHD
__ Epilepsy/seizures
__ Hearing Impairment
__ Heart disease
__ Menstrual problems
__ Mononucleosis
__ Orthopedic device
__ Strep throat
__ Visual impairment
__ Diet Restrictions
__ Other restrictions
__ Drug Allergy (What type)
__ Food Allergy (What type)
__ Insect sting allergy
__ Poison Ivy allergy
__ Other allergies

__ Special concerns ____

Explanation of any checked above: ______________________________

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Name of Family Physicians ______________________________
Contact Information for Family Physicians ______________________

Insurance Company _____________________________________
Contact Information for Insurance Company ______________________

MEDICATIONS: If your son/daughter is currently taking prescribed or over-the-counter medication, and these need to be administered during class, those medication must be up-to-date and labeled clearly in the original containers with your child's name, the name of the medication, dosage, and administration time(s). Please, inform the Director of Religious Education of these medications. All medication will be kept with the Director of Religious Education and will be made available at the designated dosage time(s).

SIGNATURE OF PARENT/GUARDIAN __________________ **DATE** _______