St. Vincent Catholic Schools – Medical Form

Please complete this form for each child K-12 so we have the most up-to-date health information for your child.

(Section 1)

Student Name: _____ **Grade:** _____

Check all that apply: **Birthday:** _____

☐ Glasses	☐ Diabetes	☐ Lung Issue
☐ Contacts	☐ Heart Problems	☐ Skin Condition
☐ History of Ear Infections	☐ Blood Disorder	☐ Blood Pressure
☐ Tube(s)	☐ Eating Disorder	☐ Orthopedic Issue
☐ Hearing Aid(s)	☐ Sleeping Disorder	☐ Neurologic Issue
☐ Allergies	☐ Bowel Issue	☐ TB Exposure
☐ Epi-pen	☐ Bladder Issue	☐ Sickle Cell Anemia
☐ Asthma	☐ Bed Wetting	☐ Headaches
☐ Inhaler	☐ Menstrual History	☐ Recent Injury
☐ Seizures	☐ Phobias	☐ Daily Medication/ADHD medicine

If any boxes were checked please explain below including specific dates, diagnoses, medications, etc.:

_____

_____

Please list any other illness, injury, or health problem that might affect performance at school:

_____

_____

(Section 2)

In the event of a serious injury or illness, when the parent cannot be contacted, an ambulance will be called to take your child to the emergency room.

Doctor or Healthcare facility preference: _____
Has student had a routine physical exam/check-up in the past 24 months? *(circle one)* YES NO

Dentist or Dental facility preference: _____
Has student had a routine physical exam/check-up in the past 24 months? *(circle one)* YES NO

Insurance *(circle one)*: Private or Employer provided Medicaid/MC+/Missouri Health Care for Children None

(Section 3)

St. Vincent Catholic Schools **do not provide** over the counter medications for their students. A **Physician Consent for Medication** form must be filled out and signed by a physician if your child requires medication, prescription or over the counter. Please contact the Health Office for more information.

Medical supplies that will be available for students include:

- Vaseline Petroleum Jelly
- Band-aids
- Hydrogen Peroxide
- Natural Tears
- Hydrocortisone Cream
- Calamine Lotion
- Antibiotic Ointment

Concerns about the use of these products should be addressed with the Health Office.

I authorize all of the above information is correct, and I authorize the use of the above named products for use on my child.

Parent Signature: _____ **Date:** _____