JSERRA CATHOLIC HIGH SCHOOL
EMERGENCY CONTACT & HEALTH INFORMATION
THIS FORM WILL NOT BE ACCEPTED UNLESS SIGNED BY BOTH PARENTS OR LEGAL GUARDIANS
FOR THE SCHOOL YEAR _____

Student Name _____ Male ____ Female ____ Birth Date _____ Grade _____
Address _____ City _____ State _____ Zip _____
E-Mail Address: _____ Fax_____

EMERGENCY CONTACTS List Contacts in order of priority

_____	_____	(___)_____	(___)_____	(___)_____
Parent/Guardian	Relationship	Home Phone	Work Phone	Cell Phone
_____	_____	(___)_____	(___)_____	(___)_____
Parent/Guardian	Relationship	Home Phone	Work Phone	Cell Phone
_____	_____	(___)_____	(___)_____	(___)_____
Other	Relationship	Home Phone	Work Phone	Cell Phone

Please note that students will be released only to persons listed on their Emergency Contact Form on file with the school. Parents may add information to their student's Emergency Contact Form by contacting JSerra. Any legal restrictions must be on file with the school in order to be implemented.****

MEDICATIONS

Please CHECK the following medications that the school is authorized to dispense to your student(s):

☐ Tylenol / ☐ Ibuprofen(Advil) / ☐ Tums / ☐ Phenylephrine (Sudafed) / ☐ Claritin / ☐ Benadryl / ☐ Triple Antibiotic Cream

The following will be administered on an as-needed basis unless parent/guardian instructs Nursing to the **contrary in writing:**
Antiseptic Spray (Benzocaine), Cough drops (Menthol), Eye Wash, Hibiclens Skin Cleanser, Safetec Sting Relief (2%Lidocaine), Vaseline Lip Balm

AUTHORIZATION HEALTH INFORMATION

Condition Please describe conditions below in detail. List additional health info on back of form.	**Description** Severity:	**Description** Frequency:	**Current Medication: Name/frequency Dosage**
Allergies (Identify) Environmental_____ Food_____ Allergic to Medications_____ Anaphylactic Reaction_____	Mild ☐ Moderate ☐ Severe ☐ Mild ☐ Moderate ☐ Severe ☐ Mild ☐ Moderate ☐ Severe ☐ Mild ☐ Moderate ☐ Severe ☐	Infreq ☐ Occass'l ☐ Often ☐ Infreq ☐ Occass'l ☐ Often ☐ Infreq ☐ Occass'l ☐ Often ☐ Infreq ☐ Occass'l ☐ Often ☐	**Epipen** student authorized to carry ☐ **Medication**_____ **Dose** _____ **Freq**. _____ *Parent/Physician Med Auth form signed_____
Asthma (Identify) Environmental _____ Exercise _____ Allergies _____	Mild ☐ Moderate ☐ Severe ☐ Mild ☐ Moderate ☐ Severe ☐ Mild ☐ Moderate ☐ Severe ☐	Infreq ☐ Occass'l ☐ Often ☐ Infreq ☐ Occass'l ☐ Often ☐ Infreq ☐ Occass'l ☐ Often ☐	**Inhaler** student authorized to carry ☐ **Medication**_____ **Dose** _____ **Freq**._____ *Parent/Physician Med Auth form signed
Diabetes (Identify) ☐ Type 1 ☐ Type 2 *Physicians orders to accompany this form	Mandatory Parent/Student meeting with Nurse prior to attending school. Meetings must be scheduled between Aug. 5th and Aug. 11th, 2014. Must provide Physician's Orders at time of meeting. Send email to nurse@jserra.org to schedule.		**Medication:**_____ *Parent/Physician Med Auth form signed
Is student taking prescribed medication at school? (Please specify reason)	Reason:		**Medication:**_____ *Parent/Physician Med Auth form signed
Seizure disorder please explain/medication:			
Mental health/ ADD/ Developmental condition			
Other Conditions please explain/medication:			
Physical handicap or limitation that hinders maximum participation in academic or athletic activities, including classroom and field trips:			

***Parent/Physician Med Auth form located on JSerra.org website, under Parent tab, under Nurse's Office.**

MEDICAL INSURANCE INFORMATION

Insurance Carrier: _____ Policy # _____ Group # _____

*Please check here if you are interested in receiving information about Dental and/or Medical Insurance for your student_____.

AUTHORIZATION

The undersigned Parent(s) or Legal Guardian of_____, authorize any representative of JSerra Catholic High School, as agents for the undersigned, to consent to any x-ray, examination, anesthetic, medical or surgical diagnosis, or treatment and hospital care that is deemed advisable by, and is to be rendered under, the general or special supervision of any physician and surgeon licensed under the provisions of the Medical Practice Act on the medical staff of any hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital. This authorization is given pursuant to the provisions of Section 25.8 or the Civil Code of California.

It is understood that effort shall be made to contact the undersigned prior to rendering treatment to the student, but that treatment will not be withheld if the undersigned cannot be reached.

The undersigned understands there are risks associated with school activities, and individually and on behalf of the above-named student, hereby expressly assume all such risks. Furthermore, the undersigned hereby unconditionally, irrevocably, and absolutely releases and discharges JSerra Catholic High School, and its officers, directors, employees, agents, successors, and assigns from any and all loss, liability or claims arising out of or in any way connected with the student's participation in school activities, unless such claims result from the willful misconduct or gross negligence on the part of the school.

PHYSICIAN INFORMATION

Physician: Name_____ Phone_____

Address:_____ FAX_____

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CONFIDENTIALITY AGREEMENT

The JSerra Catholic High School Health Office is requesting signed permission to share this information with the student's teachers, administrative staff, athletic personnel, and/or any other school staff having contact with the student. The information will be provided on a "need to know" basis only. This request is being made solely for the purpose of ensuring the health, wellness, and safety of your student while on campus or during school related activities.

ADDITIONAL HEALTH INFORMATION

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ACKNOWLEDGMENT AND AGREEMENT

Please sign below to acknowledge your understating of and consent and agreement to the foregoing.

Parent/Guardian (Print Name) _____

Parent/Guardian (Signature)_ _____ Date: _____

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