

SummerSault at Trinity School Health and Medical Emergency Information Summer 2019

Student Name:  Male  Female Date of Birth:

Home address: Home Phone:

City, State, Zip:

Parent Names and Contact Info

Table with 3 columns: Name & relationship to child, Cell Phone, Work Phone, Employer

Physician: Physician Phone: Dentist: Dentist Phone:

If neither parent can be reached, please list at least one alternate contact who can help direct your child's medical care:

Table with 4 columns: Medical Emergency Contact Names, Relationship to Child, Primary Phone, Secondary Phone

Does this child have any of the following Chronic Illnesses? If yes, please include dates and treatment notes.

- Ear Infections, Convulsions, Diabetes, Asthma, Other illness - please describe

Has this child had any of the following Diseases? If yes, please include dates.

- Chicken Pox, Rheumatic Fever, Measles, German Measles, Mumps, Scarlet Fever, Other Diseases: please describe and include dates

Allergies: Is this child allergic to any of the following? If yes, please include details, dates and treatment notes.

- Hay Fever, Insect Stings, Penicillin, Medications: please describe, Foods: please describe, Other Allergies: please describe

Has this child ever been hospitalized? If yes, please describe and include dates

Has this child ever had any operations or major injuries? If yes, please describe and include dates

Please list any prescription medications and dosage:

Does this child have any conditions which may limit their activity? If yes, please describe

My child may have Tylenol: Yes / No (circle one)

SummerSault at Trinity School may share important information on my child's Health Form with relevant Faculty/Staff

Signature: Date:

IN CASE OF AN EMERGENCY and if SummerSault at Trinity School is unable to contact either parent or guardian, I give permission for the school to secure additional medical advice and treatment at a recognized local hospital.

Signature: Date: