

SummerSault at Trinity School Health and Medical Emergency Information Summer 2019

Male  
 Female

**Student Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

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**Home address:** \_\_\_\_\_ **Home Phone:** \_\_\_\_\_

**City, State, Zip:** \_\_\_\_\_

**Parent Names and Contact Info**

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:**

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. (use back of form if needed)*

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

**Has this child had any of the following Diseases?**

*If yes, please include dates. (use back of form if needed)*

- 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. (use back of form if needed)*

- 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 *(use back of form if needed)*

**Has this child ever had any operations or major injuries?** If yes, please describe and include dates *(use back of form if needed)*

**Please list any prescription medications and dosage:** *(use back of form if needed)*

**Does this child have any conditions which may limit their activity?** If yes, please describe *(use back of form if needed)*

**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:** \_\_\_\_\_