AQUINAS HIGH SCHOOL 2022-2023 EMERGENCY FORM

Name _____ Primary Phone _____
Last First Middle

Address _____

Grade _____ Date of Birth _____ Gender _____

In any situation where there is a custody agreement, the school MUST be given the portion of that agreement that stipulates custody and any other information pertinent for the school. The requirement is a condition of enrollment. In the case of separation, please indicate custodial parent.

	Parent/Guardian	Parent/Guardian
Full Name	_____	_____
Home Address	_____	_____
	_____	_____
Phone #1	_____	_____
Phone #2	_____	_____
Phone #3	_____	_____
Email	_____	_____

Your cooperation in filling out this form will help us carry out a sound health and safety program. We need the following information in order that no difficulty arises in locating parents, guardians, or the family physician when illness or accident occurs. If the parent/guardian is unavailable, please contact the persons listed below to whom my child may be sent in case of illness or injury.

Contact 1 _____ Phone #1 _____

Phone #2 _____ Phone #3 _____

Contact 2 _____ Phone #1 _____

Phone #2 _____ Phone #3 _____

If serious accident or illness occurs that the parent/guardian cannot be reached immediately, please contact:

Doctor: _____ Phone: _____

Dentist: _____ Phone: _____

Hospital: _____

This student has Critical Alert Information: ☐ No ☐ Yes If so please describe: _____

_____

Is your student on any prescription medication: ☐ No ☐ Yes Please list medication name, dosage and time of day it is taken: _____

Are there any medical alerts, conditions or other allergies not listed above: _____

_____

The Parents/Guardians have the legal responsibility for medical expenses incurred on behalf of their child and are to notify the school whenever any of the above information changes. If the information given on this page is not truthful to the best of your knowledge, your admission to Aquinas will be refused.

Signature: _____ **Date:** _____

This is a two-page document please be sure to fill out both sides.

This information is required by the Diocese of La Crosse. Please complete the entire form.

MEDICAL MATTERS: I hereby warrant that to the best of my knowledge, my child is in good health, and I assume all responsibility for the health of my child. *(Of the following statements pertaining to medical matters, sign only those that are applicable.)*

Non-Emergency Medical Treatment: In the event it comes to the attention of the school, its officers, directors and agents, and the Diocese of La Crosse, chaperons, or representatives associated with the activities that my child becomes ill with symptoms such as headache, vomiting, sore throat, fever, diarrhea, I want to be called at the following number, to be called collect if necessary *(with phone charges reversed to myself).*

Emergency Medical Treatment: In the event of an emergency, I hereby give permission to transport my child to a hospital for emergency medical or surgical treatment. I wish to be advised prior to any further treatment by the hospital or doctor. In the event of an emergency, if you are unable to reach me at the above numbers, contact:

Name & Relationship: _____

Phone: _____ Family Doctor: _____ Phone:_____

Family Health Plan Carrier: _____ Policy #: _____

Signature: _____ **Date**: _____

Medications: If my child is taking medication, my child will bring all such medications necessary, and such medications will be well labeled. Names of mediations and concise directions for seeing that the child takes such medications, including dosage and frequency will be completed on the necessary medical forms to be kept in the office.

PLEASE CHECK ONE OF THE FOLLOWING:

☐ No medication of any type, whether prescription or non-prescription, may be administered to my child unless the situation is life threatening and emergency treatment is required.

OR

☐ I hereby grant permission for non-prescription medication *(such as acetaminophen or ibuprofen, throat lozenges, cough drops)* to be given to my child, if deemed appropriate. ***I will provide the medication and complete the Medication Form as required by the State of Wisconsin.***

Signature: _____ Date: _____

Specific Medical Information: The school will take reasonable care to see that the following information will be held in confidence.

Allergic reactions *(medications, foods, plants, insects, etc.)*:_____

Immunizations: Date of last tetanus/diphtheria immunization:_____

Does child have a medically prescribed diet? ☐ No ☐ Yes - Please Describe _____

Any physical limitations? ☐ No ☐ Yes - Please Describe_____

Is child subject to chronic homesickness, emotional reactions to new situations, sleepwalking, bedwetting, fainting?
☐ No ☐ Yes - Please Describe: _____

Has child recently been exposed to contagious disease or conditions, such as mumps, measles, chickenpox, etc.? If so, date and disease or condition: ☐ No ☐ Yes_____

The school should be aware of these special medical conditions of my child: _____

Signature: _____ Date:_____