Student Information:
Last Name_____ First Name_____

Birth date_____ Class_____ Teacher_____

Address_____ City_____ ZIP_____ Phone_____

Parent Information:
Father/Step/Guardian Name_____ Home Phone_____ Work Phone_____

Mother/Step/Guardian Name_____ Home Phone_____ Work Phone_____

Please give the names of your family physician and dentist to be called in case your child your child becomes ill or has an accident and you cannot be reached.
Physician/ Health Care Provider_____ Phone_____

Dentist/Orthodontist_____ Phone_____

Please give the names of two individuals who will be responsible for your child in case of an illness or accident until you can be reached.
Name_____ Phone_____ Relation_____

Name_____ Phone_____ Relation_____

I, the undersigned, do hereby authorize officials of Holy Trinity Academy to contact directly the persons named on this card and do authorize the named health care providers to render such treatment as may be deemed necessary in an emergency for the health of said child. In the event that the persons named on this card cannot be contacted, school officials are hereby authorized to take whatever action deemed necessary, in their judgment, for the health of said child.

_____ _____
Parent/Guardian signature Date

*******************PLEASE COMPLETE THE REVERSE SIDE OF THIS CARD.*******************

STUDENT MEDICAL INFORMATION CARD-PAGE 2

Please list the student's medical conditions_____

Does the student take any medications? _____Yes _____No

If yes, why?_____

Does the student have any allergies to medications?____Yes _____No Other allergies? _____Yes _____No

If yes, please describe._____

Please give any other information that will help us understand your child physically and/or emotionally.

_____

_____

Occasionally, your child may need medication during the school day. For these occasions, the school maintains a limited supply of over-the-counter medications. Please indicate below if you want your child to receive any of the listed medications during the school day. Medication will be administered at the school's discretion. Dosage will be consistent with the child's weight and/or age as indicated on the medication package.

Yes	No	
_____	_____	Acetaminophen (Tylenol)
_____	_____	Antibiotic Ointment

I authorize Holy Trinity Academy to give the medications checked above to my child.

_____ _____
Parent/Guardian signature Date