

Our Lady of Lourdes Catholic School

2009–2010 MEDICAL INFORMATION

PLEASE FILL OUT **ONE FORM PER CHILD** AND RETURN TO THE SCHOOL OFFICE
USE ADDITIONAL PAGES IF NECESSARY

***** PLEASE PRINT LEGIBLY *****

STUDENT NAME _____ GRADE _____

1. DOES YOUR CHILD HAVE ANY MEDICAL CONDITIONS?

_____ YES PLEASE COMPLETE THE FORM, SIGN AND DATE
_____ NO PLEASE SIGN AND DATE THE FORM

2. PLEASE LIST ANY CONDITION(S) (I.E., ASTHMA, DIABETES, ETC) THAT MAY REQUIRE SPECIAL CARE OR EMERGENCY TREATMENT. PLEASE DESCRIBE THE NEEDED TREATMENT OR SPECIAL CONSIDERATIONS.

3. PLEASE LIST ALL ALLERGIES AND ANY SPECIAL CONSIDERATIONS FOR THE ALLERGY.

4. PLEASE LIST ALL MEDICATIONS TAKEN BY YOUR CHILD ON A REGULAR BASIS AND THE REASON(S) WHY.

PARENTAL PERMISSION: I GIVE MY PERMISSION FOR SUCH DIAGNOSTIC AND THERAPEUTIC PROCEDURES AS MAY BE DEEMED NECESSARY FOR MY CHILD AT AN EMERGENCY ROOM OR NEAREST HOSPITAL. THE MEDICAL STAFF HAS MY AUTHORIZATION TO PROVIDE TREATMENT WHICH A MEDICAL PROFESSIONAL DEEMS NECESSARY FOR THE WELL-BEING OF MY CHILD. I AGREE TO BE RESPONSIBLE FOR ALL CHARGES INCURRED.

PARENT SIGNATURE

DATE