Holy Trinity Catholic School
School Health Services
2017-2018

Student Name _____ Applying for Grade _____

In the event that a student needs Prescription or Non-Prescription medication during school hours or events, it is required that those medications be provided by the parent or legal guardian. Holy Trinity Catholic School <u>will not</u> administer any medication that has not been provided by the parent.

In addition, a "Parental Authorization to Administer Medication" form (available in the school office and in the Parent/Student Handbook) must be on file with the school office for each medication to be administered. All medication must be labeled with the following information: *the date, child's name, name of doctor prescribing the medication, time of last dosage time of next dosage, and dosage amount.*

ALLERGIES OR MEDICAL CONDITIONS:

Please list allergies or medical conditions* _____

_____

***Please provide emergency instructions to deal with severe allergies or medical conditions.**
***EPI Pens must be in fanny packs provided by family.**
***If the cafeteria needs to be aware of specific food allergies, please complete the "food allergy" form, have your child's doctor sign it and return it to the school office.**

Emergency Medical Care School Consent Form:

Holy Trinity Catholic School is authorized to secure emergency medical care for my child when a parent cannot be immediately reached at the time of emergency. A parent will be responsible for the emergency medical charges upon receipt of the statement. The child will be taken to the Mercy Hospital Kingfisher or the closest hospital in the event of a field trip emergency.

_____ _____ _____
Signature of Parent/Guardian **Relationship to Student** **Date**

EMERGENCY INFORMATION

Please do not leave this section blank. It is important to be able to reach you or designated person to pick up your child in the event of illness or emergency. Please list at least 3 from different households:

1. Name_____ Relationship _____ Home Phone _____ Cell _____

2. Name_____ Relationship _____ Home Phone _____ Cell _____

3. Name_____ Relationship _____ Home Phone _____ Cell _____

Medical Information

Insurance Carrier Name _____ Policy # _____ Group # _____

Name of Physician _____Phone # _____