



# Annual Health Record

St. David's School Year 2011-2012

Name: Last \_\_\_\_\_ First \_\_\_\_\_ Grade \_\_\_\_\_ DOB \_\_\_\_\_

Allergies \_\_\_\_\_

List **ALL** Current Medications \_\_\_\_\_

Chronic Medical/Emotional Conditions (**asthma, diabetes, ADHD, others**) \_\_\_\_\_

Activity restrictions \_\_\_\_\_

Other concerns \_\_\_\_\_

Other concerns \_\_\_\_\_

Physician's Name and Phone \_\_\_\_\_

Medical Insurance Carrier \_\_\_\_\_ Policy # \_\_\_\_\_  
(may omit if same as Social Security #)

Parent's preferred email contact: \_\_\_\_\_

**In case of illness/injury please contact: (Include parents, guardians, and emergency contacts in order of preference, and please note any custodial issues)**

1. \_\_\_\_\_ Home # \_\_\_\_\_

Relationship \_\_\_\_\_ Mobile # \_\_\_\_\_

Work # \_\_\_\_\_

2. \_\_\_\_\_ Home # \_\_\_\_\_

Relationship \_\_\_\_\_ Mobile # \_\_\_\_\_

Work # \_\_\_\_\_

3. \_\_\_\_\_ Home # \_\_\_\_\_

Relationship \_\_\_\_\_ Mobile # \_\_\_\_\_

Work # \_\_\_\_\_

### Emergency Release

I also authorize the employees of St. David's School to consent on my/our behalf to any examination and/or medical or surgical diagnosis or treatment, including emergency or hospital care deemed advisable and rendered by a licensed physician, certified EMT or other agent of either. It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care, but is given to provide advanced authority of such agents to consent to all diagnosis and treatment. I/We acknowledge that I/we will remain responsible for the cost of such treatment.

### Medical Information Release

I authorize the School Nurse at St. David's School to provide information to the faculty/staff regarding the health of my son/daughter. I understand that this information may include any or all of the medical information provided by myself or my son/daughter's physician. I understand that this information will be readily available to faculty/staff, but will be treated as confidential information.

\_\_\_\_\_  
Parent's Signature Date Hospital Preference