



Annual Health Record

St. David's School Year 2010-2011

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