

**PIUS XI CATHOLIC HIGH SCHOOL
HEALTH SNAPSHOT
2018-19 School Year**

This form is to be completed for every child. **The requested information will inform emergency personnel and school staff of any medical condition your child may have.** If we cannot contact a parent/guardian, signing this form gives consent for us to make a decision to transport the child to the nearest hospital.

The following information is accurate to the best of my knowledge:

Student Name: _____

DOB _____ Graduation Year _____

Medical History: Please check all that apply and provide additional information as needed in the space below.

- | | |
|---|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Hearing Impairment (__left __ right) |
| <input type="checkbox"/> Anemia/ Blood Disorder | <input type="checkbox"/> Heart Condition |
| <input type="checkbox"/> Arthritis/ Fibromyalgia | <input type="checkbox"/> Hypoglycemia |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Chemical Imbalance (prone to depression) | <input type="checkbox"/> Visual Impairment (blind or partially blind) |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Other: (please specify) |
| <input type="checkbox"/> Epilepsy/ Seizure | <input type="checkbox"/> None |

Additional Information: If you checked yes for any of the above, please provide additional information about the condition, treatment or special accommodations that may exist.

Medication: Please list any prescribed or over the counter medication that your child regularly uses. List medication, dose and frequency.

Primary Care Physician: _____ Physician Phone #: _____

PARENT/GUARDIAN PHONE NUMBERS:

PARENT/GUARDIAN: _____ PHONE # _____

PARENT/GUARDIAN: _____ PHONE # _____

PARENT/GUARDIAN SIGNATURE: _____ Date: _____

ALTERNATE EMERGENCY CONTACT PERSON IF PARENT/GUARDIAN CANNOT BE REACHED:

SPECIAL NOTES: