Gehlen Catholic School
Health & Safety Emergency Information

Parents' Name_____
Father's Occupation/Employer_____Work Phone_____ Cell_____
Mother's Occupation/Employer_____Work Phone_____Cell_____

List two people who have agreed to accept responsibility in the event you cannot be reached:

Name/Relationship_____Work Phone_____ Cell_____
Name/Relationship_____Work Phone_____ Cell_____

There is room on the backside to explain an medical conditions your child may have.

Student Name_____
Last First Middle Gender Birth Date Grade

ADD/ADHD_____Allergies_____Asthma___Bladder/Bowel Problems_____Diabetes_____Glasses/Contacts_____Hearing Loss_____Heart Condition_____Migraine/Headaches_____Seizure Disorder_____

Other Medical Diagnosis/Medical Treatments/Equipment Used_____
Takes regular medication(s)? List medication(s) _____

Student Name_____
Last First Middle Gender Birth Date Grade

ADD/ADHD_____Allergies_____Asthma_____Bladder/Bowel Problems_____Diabetes_____Glasses/Contacts_____Hearing Loss_____Heart Condition_____Migraine/Headache_____Seizure Disorder_____

Other Medical Diagnosis/Medical Treatments/Equipment Used_____
Takes regular medication(s)? List medication(s) _____

Student Name_____
Last First Middle Gender Birth Date Grade

ADD/ADHD_____Allergies_____Asthma_____Bladder/Bowel Problems_____Diabetes_____Glasses/Contacts_____Hearing Loss_____Heart Condition_____Migraine/Headaches_____Seizure Disorder_____

Other Medical Diagnosis/Medical Treatments/Equipment Used_____
Takes regular medication(s)? List medication(s) _____

Student Name_____
Last First Middle Gender Birth Date Grade

ADD/ADHD_____Allergies_____Asthma____Bladder/Bowel Problems_____Diabetes_____Glasses/Contacts_____Hearing Loss_____Heart Condition_____Migraine/Headaches_____Seizure Disorder_____

Other Medical Diagnosis/Medical Treatments/Equipment Used_____
Takes regular medication (s)? List medication (s)_____

PLEASE CONTINUE TO THE BACK SIDE

Comments: Use this space to further describe an concerns or problems you indicated on the front page.

I give permission for the school nurse to administer to my child, as appropriate and per manufacturer's instruction, the following Over-The-Counter (OTC) products as checked. These preparations may be administered throughout the current school year without prior phone call:

Acetaminophen	Yes___No___Call___	Benadryl	Yes___No___Call___
Ibuprofen	Yes___No___Call___	Antacid	Yes___No___Call___
Antibiotic Ointment	Yes___No___Call___	Eye Drops	Yes___No___Call___
Anbesol	Yes___No___Call___	Hydrocortisone	Yes___No___Call___
Cough Drop	Yes___No___Call___		

Students MUST bring in their own OTC medication if utilizing the school's supply on a regular basis. The nurse will notify the parents if this is happening and medication will then need to be sent in. All medications sent to school MUST be in the original container, labeled with the child's name. **Note: Students requiring prescription medication during the school day must present a note to that effect to the school nurse.** All medication will be kept under lock and key rather than storing it in places to which other students have access.

Parent/Guardian Signature:_____

In case of emergency, permission is given for my child to receive immediate first aid and/or treatment as necessary. I also give consent for school personnel to use their own judgement in securing medical aid and ambulance services or in the even that I cannot be reached. Yes_____No_____

The above information is confidential in nature and will be used only to meet genuine health emergencies. Please notify the school, in writing, of any significant changes in the above information throughout the school year.

Parent/Guardian signature:_____**Date:**_____