STUDENT EMERGENCY CARE FORM

2016-2017

Student's Name: Last _____ First _____ MI _____ Date of Birth _____ Age _____ Gender _____ Grade _____

Social Security #: _____ Weight: _____ Height: _____

Father/Guardian's Name: _____ Mother/Guardian's Name: _____

Address: _____ Address: _____

City: _____ Zip: _____ City: _____ Zip: _____

Phone #: _____ (Home) _____ (Work) Phone #: _____ (Home) _____ (Work)

_____ (Cell) _____ (Pager) _____ (Cell) _____ (Pager)

Father's Employer: _____ Mother's Employer: _____

E-Mail Address: _____ E-Mail Address: _____

LIST PERSONS TO BE CONTACTED IN EMERGENCY WHEN PARENTS / GUARDIAN CANNOT BE REACHED:

Name: _____ Relationship: _____ Employer: _____

Home Phone #: _____ Work Phone #: _____ Cell Phone #: _____

Name: _____ Relationship: _____ Employer: _____

Home Phone #: _____ Work Phone #: _____ Cell Phone #: _____

Name: _____ Relationship: _____ Employer: _____

Home Phone #: _____ Work Phone #: _____ Cell Phone #: _____

MEDICAL INFORMATION

Doctor's Name: _____ Office: _____ Emergency #: _____

Dentist's Name: _____ Office: _____ Emergency #: _____

Insurance Carrier: _____ Group Policy #: _____

List allergies (drug/food environmental, etc.): _____

List medical Condition (ex. Diabetes): _____

Medications taken daily or as needed (name, dosage & frequency): _____

Can this information be released to school personnel? _____

Daily Monitoring required (glucose monitoring): _____

I, _____, do hereby authorize school administration to render first aid for illness or injury to my child named above. In the event of a medical emergency, I authorize school administration to have my child transported to the nearest hospital/emergency care center for emergency medical or surgical treatment and to contact my child's physician and one of the persons listed above. I further authorize the release of the above medical information to all medical personnel providing treatment. I agree to be solely responsible for the payment of all expenses incurred in such an emergency.

I do hereby release, hold harmless and indemnify the Most Reverend Daniel Cardinal DiNardo of the Archdiocese of Galveston-Houston and his successors in office, the Archdiocese of Galveston-Houston, St. Mary Magdalene Catholic School and any other of their officers, agents, employees or representatives ("Released Parties") from any and all liability, claims, losses or expenses arising from personal injury, death, or loss of or damage to property arising from any medical treatment received and/or transportation to the nearest hospital/emergency care center.

_____ _____

Signature of Parent or Guardian Date

PLEASE KEEP CURRENT THROUGHOUT THE YEAR

PHYSICAL EXAMINATION FORM

Student's Name: _____Height: _____Weight: _____ Pulse: _____ Blood Pressure: _____

Vision R 20/____ L 20/____ Corrected: Yes___ No___ Pupils: Equal ___ Unequal ___

Hearing: Normal ____Referred _____ Spinal Exam: Normal ____ Referred _____ % Body Fat (optional)_____
Bend Test: Normal ___ Referred ___

MEDICAL	NORMAL	ABNORMAL FINDINGS	INITIALS
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart-Auscultation of the heart in the supine			
Heart-Auscultation of the heart in the standing position			
Heart-Lower extremity pulses			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			

MUSCULOSKELETAL			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

CLEARANCE

† Cleared for Participation

† Not cleared for Participation Reason: _____

Recommendations and/or Restrictions: _____
_____

The following information must be filled in and signed by either a Physician, a Physician Assistant licensed by a State Board of Physician Assistant Examiners, or a Registered Nurse recognized as an Advanced Practiced Nurse by the Board of Nurse Examiners.

Name (print/type): _____ Date of Examination: _____

Address: _____ Phone Number: _____

Signature: _____ Title:_____