

SAINT THOMAS ACADEMY
Consent to Share Student Health Data

Dear Parent/Guardian,

In order to assure the health and safety of your child in school, **it is your responsibility to share and update all health concerns with the Health Office.** A student's health record is classified as confidential information. Your signature at the bottom of this form indicates an understanding that will allow the school health service staff to share health concerns with appropriate school personnel who have direct contact with you child during the school day. Examples of these types of health concerns include, but are not limited to, the following conditions: diabetes, asthma, heart conditions, seizures, side effects of medications and/or allergic reactions to food or insect bites.

Thank you for your cooperation in this matter.

Sincerely,

Health Office

PLEASE COMPLETE THE FOLLOWING:

Student's Name _____

Student's Date of Birth _____

Student's Health Concern(s) _____

Please list all medications that you child is currently taking: _____

My signature indicates that I have read this letter and give written consent to allow the school health office to share the above student's health concerns with appropriate school staff.

Parent/Guardian Signature _____ Date _____

Consent for school health office staff to administer Ibuprofen/Tylenol _____
Please initial

Dose _____ Frequency _____

Students in Middle School may not be administered Ibuprofen/Tylenol without a physician's signature: _____

Physician's Signature

OVER

HEALTH SERVICES EMERGENCY INFORMATION
(A separate form needs to be completed for each student enrolled in school)

Name of Student Grade _____ Date of Birth _____

Street City _____ State _____ Zip _____

Home Phone Number

Mother/Guardian's Name Home Phone Number _____

Work Phone Number Cell Phone Number _____

Father/Guardian's Name Home Phone Number _____

Work Phone Number Cell Phone Number _____

Name of Family Physician Phone Number _____

Name of Family Dentist Phone Number _____

Choice of Hospital Phone Number _____

List neighbors or nearby relatives to contact if parents are unavailable:

Name Phone Number _____

Name Phone Number _____

In case of an accident or serious illness, I request the school contact me. If the school is unable to contact me, I hereby authorize designated school personnel to call the physician indicated and to follow his/her instructions. If unable to contact the physician, designated school personnel may make whatever arrangements are deemed necessary.

Signature of Parent/Guardian Date _____