School of St. Philip
Student Health Emergency Form

Student's Full Legal Name: ______________________________**Birthdate**:_____________**Grade:** ____

Emergency Contact if Parent(s) cannot be reached

Name: ____________________________

Address: ____________________________

City, State, Zip: ___________________________

Home Phone: __________________

Work Phone: __________________

Cell Phone: __________________

Name: ____________________________

Address: ____________________________

City, State, Zip: ___________________________

Home Phone: __________________

Work Phone: __________________

Cell Phone: __________________

Doctor Contact

Name: ________________________

Phone: ________________________

Dentist Contact

Name: _______________________

Phone: _______________________

Early Childhood Screening (Preschool Screening) is now required for Kindergarten entrance.
Has your child been screened? Yes No
Was your child screened in this district? Yes No
If NO, where? ________________________

Does your child have glasses, contacts, P.E. tubes, hearing aids? Yes No

Food allergies causing: rashes anaphylaxis Circle one or both

The food or allergen to be avoided: ____

List of foods to be avoided and foods to be substituted: ____

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Other non-food allergies: ____

List any other health conditions, any medication on a regular basis, injuries, restrictions of child's activities, operations or major illnesses: ____

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I authorize the School of St. Philip to obtain immediate medical care for my child: _________________________
Student's Name

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Parent/Guardian Signature Date