FORM 10

CONFIDENTIAL HEALTH RECORD PERSONAL INFORMATION

IMPORTANT: THIS FORM MUST BE COMPLETED IN FULL AND RETURNED. **PLEASE PRINT**

NAME_____**DATE OF BIRTH:** _____
(Last) (First) (Middle) Mo/Day/Yr

PHONE: _____ **GRADE (entering in Sept.):**_____ **SEX: Female**_____ **Male**_____

ADDRESS: _____
(Street) (City) (State) (Zip)

SCHOOL PREVIOUSLY ATTENDED: _____
(Name) (Address) (Phone)

NAME STUDENT'S PHYSICIAN: _____
(Name) (Address) (Phone)

Has your child been treated/ diagnosed with any of the following:
PLEASE CHECK ANY THAT APPLY.

- Asthma _____
- Asthma which requires the use of an inhaler _____
- Allergies (*specify* _____) _____
- Allergies which requires the use of an Epi-Pen (*specify* _____) _____
- Cardiac condition (*describe*_____)
- Seizure, Neurological disorder, or history of concussion _____
- ADD/ADHD _____
- Gastrointestinal disorder (*describe* _____) _____
- Diabetes _____
- Daily medication *(please list)*
  _____
- Fainting _____
- Migraine headache _____
- Hearing Impaired _____
- Visually Impaired _____
- Under physician care for any medical problems or recent surgery? _____
  _____

Check Accordingly:

O My child may participate in routine nursing services for illness and accidents.
These services are offered **free of charge**.

O My child may participate in routine screenings for Vision, Hearing & Scoliosis.
These services are offered **free of charge.**

If medication is required, supplemental forms will be mailed to your home address and will also be available on the bgahs.org website.

I certify that all the information provided is accurate to the best of my knowledge, and may be shared with school personnel if necessary to assure the health of the student.

Existing Legislation, Chapter 226-Laws of 1991, provide certain nursing services and funding for all full time students in private schools. Included in these services, based on available state aid, is maintenance of all student health records, hearing assessment, and scoliosis screening. In addition, your child will receive emergency nursing for any school related illness or injury.

IN THE EVENT AN EMERGENCY ARISES I GIVE ST. THOMAS AQUINAS HIGH SCHOOL DESIGNATED PERSONNEL PERMISSION TO TREAT ACCORDINGLY, AND TAKE MY CHILD TO THE NEAREST HOSPITAL.

PARENTAL CONSENT:

Signature: _____ Date: _____