BISHOP CONNOLLY
HIGH SCHOOL

373 Elsbree Street
Fall River, MA 02720
tel 508.676.1071
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EMERGENCY HEALTH INFORMATION/ AUTHORIZATION FOR MEDICAL TREATMENT FORM 2019 – 2020

PLEASE FILL OUT **BOTH** SIDES.

STUDENT NAME ______________________________
LAST FIRST MIDDLE INITIAL GRADE

ADDRESS ______________________________
NO. STREET CITY/TOWN ZIP

DATE OF BIRTH ____________________ ☐ MALE ☐ FEMALE PHONE ____________________

PARENT/GUARDIAN NAME ______________________________

PHYSICIAN NAME ____________________ PHYSICIAN PHONE ____________________

PHYSICIAN ADDRESS ______________________________

Please fill in the following information, which is important in the case of serious illness or emergency.
Please notify the school nurse of any changes in student health history or changes in medication.

Please provide insurance information:

____
POLICY NAME POLICY NUMBER SUBSCRIBER'S NAME

Allergies: Please list all allergies, including medications, foods and insects. Describe the allergic reaction.

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Hearing problems: ☐ Yes ☐ No Accommodations: ______________________________

List any medical conditions, serious illnesses, injuries or sugeries:

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List medications taken on a regular basis, including dosage, time taken and the reason the medication is taken:

MEDICATION	DOSE	TIME TAKEN	REASON FOR TAKING MEDICATION

Please refer to medication administration policy in the student handbook. Medication forms are needed for any medication given to students at school. Please see medication forms under Health Office Forms on our website.

Is there any additional information that the school nurse should be aware of? Please explain.

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Please review and circle the following:

I wish my child to be allowed to receive 1–2 ibuprofen tablets, extra-strength Tylenol tablets, Tums, or cough drops from the school nurse or school personnel designated by the school nurse.

Yes / No

I grant to Bishop Connolly High School and its agents, my permission to seek emergency medical attention for my child if, in their judgment, such attention is warranted and I am not immediately available to grant such permission, including transportation by ambulance.

Yes / No

I give permission for the school nurse to share pertinent medical information with the school staff.

Yes / No

I give permission for the Bishop Connolly High School medical staff to share any pertinent medical information concerning my child to EMTs, team trainer, or other physicians, in relation to any incurred injury or illness sustained by my child while at school.

Yes / No

I verify that the responses on the Authorization for Medical Treatment form are true to the best of my knowledge.

Yes / No

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PARENT/GUARDIAN SIGNATURE DATE