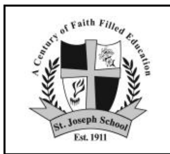

St. Joseph Interparochial School
416 Church Avenue
Bowling Green, KY 42101

EMERGENCY MEDICAL RELEASE AND HEALTH INFORMATION FOR MINORS

PURPOSE: Information contained in this document is confidential and is intended to be viewed/utilized only by specified SJS staff needing access to privy information for the student's health & safety. This information is protected by Family Educational Right to Privacy Act (FERPA) & Health Insurance Portability And Accountability Act Of 1996 (HIPAA).

Student's Name____ Name Preference______________________
(Last) (First) (Middle)
School Year 20 _____- 20______ Age ________ Birthday________/_______/________ Gender_________ Grade ________
Mailing Address____ City/State/ZIP________________________
County______________________

EMERGENCY INFORMATION: (Circle Name and Phone # to be Contacted 1st)

Father's or Legal Guardian's Name___________________________________ **Home** Phone____________________
Home Address____ **Cell** Phone_____________________
Employer____ **Work** Phone ____________________
E-mail address____

Mother's or Legal Guardian's Name__________________________________ **Home** Phone____________________
Home Address____ **Cell** Phone_____________________
Employer____ **Work** Phone _____________________
E-mail address ____

If parent/guardian cannot be reached, who may be contacted for emergency &/or can pick up student if ill? (not parent)
1. Name_____________________________ Relationship________________ Phone_______________ Cell________________
2. Name_____________________________ Relationship________________ Phone_______________ Cell________________

Please answer the following:

- I hereby consent to the use of a photograph of my child for the purpose of publication. _____Yes _____No
- List anyone who, by court order or decree is designated as the **primary or sole custodial parent**: _______________________
- Name anyone who has been **restrained from picking up** the child: (Court Documents to that effect must be on file in the school office.) ____

PERMISSION FORM & LIABILITY RELEASE

PURPOSE: This Permission Form/Liability Release is intended to cover all diocesan-, deanery-, parish-, and Catholic school sponsored activities for anyone under the age of eighteen (18). Catholic schools and/or programs have the right to require parent/guardian to give permission for students/participants eighteen (18) years of age or older. I/We, the parent(s) and/or legal guardian(s) of ____________________________________ (child's name), hereby request permission for this child to participate in any and all of the activities of the Roman Catholic Diocese of Owensboro and St. Joseph School. I/We release from responsibility any person transporting my/our child to or from activities. I/We understand the possibility of unforeseen hazards and know the inherent possibility of risk. Taking into account the subject's age, I/we believe that the subject of this release is physically and mentally capable of taking reasonable precautions to protect his/her own safety and has the maturity and judgment not to put himself/herself or others in dangerous situations.

Parent/Guardian Signature:______________________________ **Date:**____________

IF THERE ARE ANY CHANGES IN THE INFORMATION ON THIS FORM, IT IS YOUR RESPONSIBILITY TO NOTIFY THE APPROPRIATE LEADER AND GET THE FORM UPDATED. (e.g. insurance policy changes, changes in medical condition or medicines, court orders, etc.)

St. Joseph School 416 Church Avenue, Bowling Green, KY 42101

EMERGENCY MEDICAL RELEASE AND HEALTH INFORMATION FOR MINORS

School Year: 20___-20___ Grade _____ Student's Name____________________________________ Birthday_____/______/______ Age _____
(Last) (First) (MI)

Is Current Immunization Certificate on file at school? ____________ Pediatrician/Physician: ____

Asthma/Allergy Physician: ________________________________ Other Physicians (i.e. Heart, Diabetic)___________________________________

Health Insurance Information Name of Health Insurance Company: ____

Insurance Policy # ______________________________ Insurance Certificate # _____________________________

Health Concern	NO	YES	
Allergy to Food(s)			****If New Diagnosis, Contact School Office for Plan of Care**** **EPI-PEN:** YES ________ NO _______ List & Describe reaction to **EACH:**
Allergy to Insect Stings: (i.e. Bees/Wasps) _____ ("X") unknown reaction/Has Not had sting exposure			****If New Diagnosis, Contact School Office for Plan of Care**** **EPI-PEN**: YES ________ NO _______ Describe reaction:
Allergy to Latex			**EPI-PEN:** YES ______ NO _____ Describe reaction:
Allergy to Medication(s)			List & Describe reaction to EACH:
Asthma			****If New Diagnosis , Contact School Office for Plan of Care**** Will **INHALER** be kept at school?: YES _____ NO _______ List Inhaler Name & directions:
Circle if applicable: ADD or ADHD			List Medication and dosage: ______None ______ Given at home ______ Needs to be given at school
Behavior/Emotional Concerns			Describe:
Frequent Headaches/ Migraines			Describe: Medication:
Stomach Problems			Describe: Medication:
Hearing Problems			Describe: **Right** Ear____ **Left** Ear____ **Hearing Aides:** YES ____ NO _____
Visual Conditions:			**Glasses:** YES ____ NO ____ **Contacts**: YES ____ NO ____ Other:
Diabetes:			****If New Diagnosis, Contact School Office for Plan of Care**** **Glucagon**: YES ______ NO _____
Heart Condition(s)			Describe:
Seizures/Epilepsy			****If New Diagnosis ,Contact School Office for Plan of Care**** Describe: Medication: **Diastat?** YES ______ NO _____
Activity Restrictions			Describe:
Other Medical Concerns --i.e. pre-existing medical conditions, disabilities, physical handicaps, major illnesses, all surgeries, etc.			Describe:
List any student medication(s) not listed above, even if taken at home			Name, dosage, & time given: Will any need to be given at school? YES _______ NO _______

Consent for Emergency Care: I/We, the undersigned parent(s)/guardian of _________________________________do hereby request and give permission for the provision of necessary medical treatment for the above-named child. I/we understand that supervisory personnel will immediately seek to reach the above-named child's contact(s) in case of a medical emergency. If any injury/incident does occur during this event that requires transportation to a hospital or doctor, I/we give permission for a representative of the parish/school/etc. to secure necessary medical attention. I/we further authorize any duly qualified physician, dentist, or hospital to render such aid or treatment that may be necessary and understand that I/we assume responsibility for the cost of any such treatment. I/we authorize the release of pertinent medical information to supervisory personnel. * Please understand that, depending upon the seriousness of the situation, your child may be transported to the nearest hospital.

Parent/Guardian Signature:__________________________________ Date:_____________