Child's Health Information

Date of child's last physical exam:	Child's health care provider	Phone Number ( ) -	
Street address		City	Zip code
*Special health problems? Yes or No? If yes, please specify	*List an allergies, including drug reactions. Yes or No? If yes, please specify	*Does your child have asthma? Yes or No? If yes, please specify	Does your child require an Epipen? Inhaler? If yes, please specify

**If your child has ony allergies or asthma, or his or her health requires Individual or special care, you must also complete an individual plan of care form with your child's doctor. Forms are available.*

Regular medications? Yes or No? If yes, please specify	Does the medication need to be given at school? Yes or No? Note: Medication can only be given at school with signed permission by the doctor and parents. Forms are available.	Has your child had any problem with vision? Yes or No? Do they wear eyeglasses? Yes or No?
Does your child have any limitations or disabilities? Yes or No? If yes, please specify	Has your child had any problems with hearing? Yes or No? Do they wear aids?	Has your child had any serious illness, operation, hospitalization or injuries? Yes or No? If yes, please specify

Child's dentist's name	Phone Number ( ) -	
Street address	City	Zip Code

Child's Medical Insurance Coverage

insurance Company Name	Member/Policy Number
Policy Holder Name	Employer Name
Insurance Company Name	Member/Policy Number
Policy Holder Name	Employer Name

Consent to Medical Care and Treatment of minor children

I give permission that my child, _____, may be given first aid/emergency treatment by the qualified staff at Our Lady of Guadalupe School. (In an emergency we will always call 911 first.)

I authorize you to call Dr. _____ Phone: _____

My choice of hospital is: _____ or: _____

Parent/guardian signature	Date	Parent/guardian signature	Date

When I cannot be contacted, I authorize and consent to medical, surgical and hospital care, treatment and procedures to be performed for my child by a licensed physician, health care provider, hospital or aid car attendant when deemed necessary or advisable by the physician or aid care attendant to safeguard my child's health. I waive my right of informed consent to such treatment. I also give my permission for my child to be transported by ambulance or aid car t o an emergency center for treatment. I certify under penalty of perjury under the laws of the State of Washington that this information is true and correct.

Parent/guardian signature	Date	Parent/guardian signature	Date

Parents: If your child has a life-threatening illness, it is the parent/guardian's responsibility to notify the school prior to school attendance. For the safety of your child, this information will only be shored with those who hove a need to know.