

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

Allergies: _____

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

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

Parent/Guardian Signature

Date