

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