

2012-2013

Grade \_\_\_\_\_

**CLINIC CARD**  
**St. Pius X Catholic High School**  
**School Health Information**

STUDENT \_\_\_\_\_

Last Name

First Name

BIRTHDATE \_\_\_\_\_  Male  Female

ADDRESS \_\_\_\_\_  
\_\_\_\_\_

HEALTH HISTORY - ANSWER YES OR NO

ALLERGIES (SPECIFY) \_\_\_\_\_

PHYSICAL HANDICAPS \_\_\_\_\_ DIABETES \_\_\_\_\_

ASTHMA \_\_\_\_\_ SEIZURE DISORDER \_\_\_\_\_

ATTENTION DEFICIT \_\_\_\_\_ CANCER \_\_\_\_\_

OTHER PHYSICAL OR MENTAL HEALTH ISSUES WHICH MAY BE A CONCERN AT SCHOOL:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_ Does your child require special seating in the classroom? Specify \_\_\_\_\_

\_\_\_\_\_ Does your child have any condition that would limit physical education activities? List \_\_\_\_\_

\_\_\_\_\_ Does your child take any prescribed medications routinely? List \_\_\_\_\_

\_\_\_\_\_ Did your child receive any immunizations this past year? List type and date \_\_\_\_\_

\_\_\_\_\_ Date of last tetanus shot \_\_\_\_\_

**EMERGENCY CONTACT INFORMATION**

Please indicate custodial parent when applicable

Father \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
Cell Phone \_\_\_\_\_  
E-mail \_\_\_\_\_

Mother \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
Cell Phone \_\_\_\_\_  
E-mail \_\_\_\_\_

If parents cannot be reached, list two people who will assume care of your child:

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Child's Physician \_\_\_\_\_ Phone \_\_\_\_\_

School clinic personnel have my permission to contact my child's physician for further medical information. In case of serious illness or injury, the school will telephone Emergency Medical Services, for immediate transportation to the nearest hospital. I, the parent/legal guardian, authorize the transport of and treatment by the hospital emergency staff for my child, \_\_\_\_\_

Parent signature \_\_\_\_\_ Date \_\_\_\_\_