



HEALTH FORM/EMERGENCY CONTACT

Student Name: _____ Date of Birth: _____

Student's primary care physician/source of medical care: _____

Phone number: _____

Preferred Hospital: _____

Allergies (other than seasonal): _____

Has your child had a severe (anaphylactic) reaction requiring emergency care? If yes please explain. _____

List any illnesses or health problem which you or your family physician feel the school authorities should know.

Recurring illness: _____

Operations/Surgeries: _____

Emotional problems: _____

Serious accidents: _____

Fractures: _____

Is this student at present under medical treatment? Yes No If yes, for what? _____

Tolton Catholic High School is required to have current immunization records for all students. These will be requested if not provided with your student's permanent records.

EMERGENCY CONTACT INFORMATION

First Contact/Relationship to Student Phone # 2nd Phone # (work)

Second Contact/Relationship to Student Phone # 2nd Phone # (work)

The following individuals should NOT be contacted and may NOT remove my child from school.
