

Student's Full Legal Name: _____
Last First Middle Used First Name

Grade in Sept 2011: _____ Date of Birth: _____ Age on Sept 1, 2011 _____ years old

Student's Home Phone: _____ Secondary Phone: _____ Student's Cell Phone: _____

Home Address: _____
Street City/Town Zip Code

Does the student live at more than one household? Yes No If Yes, please briefly give schedule: _____

Secondary Address: _____
Street City/Town Zip Code

Note: -If you child has shared, separation, divorce, or custody arrangements of any type, you must fill out an Additional Parent Information sheet for us to have on file. Call the school office right now at 934-4240 if you have not filled one out yet and we'll send one to you. Thank you.

Mother's Name & Address: _____

Mother's Home Phone: _____ Work Phone: _____ Cell Phone: _____

Mother's Contact Email Address: [print clearly, please] _____

Father's Name & Address: _____

Father's Home Phone: _____ Work Phone: _____ Cell Phone: _____

Father's Contact Email Address: [print clearly, please] _____

Required Alternate Contacts: Please list two individuals who can assume temporary responsibility for your child if you cannot be reached

Name: _____ Phone / Cell #: _____ Relationship: _____

Name: _____ Phone / Cell #: _____ Relationship: _____

Student's Name _____ DOB _____

Please list any significant health problems that would be important to a physician evaluating you child in case of an emergency.

Please list any allergies to medications etc.

Has the student been prescribed an inhaler or epipen? _____

Is the student presently taking medication? _____ If so what type? _____

Does the student wear contact lenses? _____ Date of last Tetanus shot _____

In the event that I cannot be reached in an emergency, I hereby give permission to physicians selected by coaches and staff of Sant Bani School to hospitalize, secure proper treatment for and to order injection and/or anesthesia and/or surgery for the person named above.

Daytime phone number: _____ Evening phone number: _____

*Emergency Permission Form may be reproduced to travel with teams and on extended field trips and is acceptable for emergency treatment if needed.

Parent Signature: _____ Print Name: _____ Date: _____

Attn: **Linda Surowiec** Sant Bani School --- Student Health Info Entering Grade _____ **Part II.**

Student's Full **Legal Name:** _____
Last First Middle Date of Birth

Has the student had any of the following diseases or medical conditions? If yes, please indicate age at the time and explain further.

Asthma: Yes No Triggers: _____ Medications/Treatments*: _____

Seizures: Yes No Type: _____ Medications/Treatments*: _____

Diabetes: Yes Type I Type II No Current Medications/Treatments*: _____

Serious injuries or illnesses and/or notable changes in the student's health (please explain, use another sheet as needed): _____

Does the student require glasses or contact lenses at school: Yes No Just for reading or all the time: _____

Known Drug Allergies: _____

Severe Environmental Allergies: _____

Other Daily Medications & Time of Administration*: _____

() I agree to supply the school health office with the necessary documentation of any changes in daily medications as soon as they occur.

***If medications are taken at school, an authorization form must be completed. This form is located on the school's website and/or through the school's health office. Cough drops, ibuprofen and acetaminophen may be given to high school aged students without written authorization from parents.

Record of immunizations (please see enclosed paperwork for requirements):

Immunization	Dates Given
DTP/Dt/DtaP/Td/Tdap	
Polio	
Measles	
Rubella and Mumps	
Hepatitis B Vaccine	
Varicella (Chicken Pox) Vaccine	

******NH Statute states that a child may be exempt from immunizations only if:*

1. A licensed physician certifies that immunization against a particular disease may be detrimental to the child's health; or
2. A parent or legal guardian objects to immunization because of religious beliefs and signs a notarized form stating that the child has not been immunized because of religious beliefs.

Primary Care Physician: _____ Office Address and Phone #: _____

Health Insurance Company Name: _____ ID #: _____ Group #: _____

I hereby give permission for such diagnostic, therapeutic, and/or operative procedures to be performed on my child, _____
_____ in an emergency where delay in treatment would, in the opinion of medical authority be clearly harmful. I understand that the responsibility implied by this signature will be assumed only if absolutely necessary.

Parent Signature: _____ Print Name: _____ Date: _____