Trinity Catholic School
STUDENT INFORMATION/EMERGENCY CONTACT

NAME____ DATE________________________
DOB______________________________AGE____________ CIRCLE ONE MALE FEMALE
GRADE________________ HOMEROOM (NUMBER AND TEACHER)____

PARENT/GUARDIAN INFORMATION:

NAME____________________________________ RELATIONSHIP TO STUDENT ________________________
ADDRESS____ STUDENT LIVES WITH _______YES_________no
HOME PHONE #_________________ CELL PHONE #__________________ WORK PHONE #________________

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ADDRESS____ STUDENT LIVES WITH _______YES_________no
HOME PHONE #_________________ CELL PHONE #__________________ WORK PHONE #________________

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ADDRESS____ STUDENT LIVES WITH _______YES_________no
HOME PHONE #_________________ CELL PHONE #__________________ WORK PHONE #________________

NAME____________________________________ RELATIONSHIP TO STUDENT ________________________
ADDRESS____ STUDENT LIVES WITH _______YES_________no
HOME PHONE #_________________ CELL PHONE #__________________ WORK PHONE #________________

REQUIRED LEGAL DOCUMENTS PROVIDED TO SCHOOL _________________YES ________________NO

EMERGENCY PICK UP LIST:

Please note in the event school is unable to contact parent/guardian the following names will be contacted to pick up your child from school. Anyone NOT on this list will NOT be allowed to pick up your child.

NAME____RELATIONSHIP TO STUDENT________________________
HOME PHONE #_________________ CELL PHONE #__________________ WORK PHONE #________________

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HOME PHONE #_________________ CELL PHONE #__________________ WORK PHONE #________________

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MEDICAL UPDATE

NAME_____ DATE_____

DOB_____AGE_____ **CIRCLE ONE** MALE FEMALE

GRADE_____ HOMEROOM (NUMBER AND TEACHER)_____

ALLERGIES_____ MEDICAL ALERT(S) _____

IF EITHER REQUIRES MEDICATION OR TREAMENT PLEASE EXPLAIN_____

_____

SINCE LAST SCHOOL YEAR HAS YOUR CHILD BEEN INJURED OR HAD AN ILLNESS THAT REQUIRED MEDICAL ATTENTION? _____ YES _____ NO

IF YES PLEASE EXPLAIN_____

_____

_____

IF YOUR CHILD REQUIRES DAILY/REGULAR MEDICATION PLEASE EXPLAIN_____

_____

_____

IF YOU WANT YOUR CHILD TO RECEIVE THESE OVER THE COUNTER MEDICATION COMPLETE THE FOLLOWING AND RETURN TO SCHOOL, **PARENT AND MEDICAL PROVER SIGNATURE ARE <u>BOTH</u> REQUIRED.**

Tylenol/Acetaminophen 325mg for pain or fever every 4 hours	Y_____	N _____
Children's Tylenol/Acetaminophen 80mg/chewable tablet (according to manufacturer's specification) for pain or fever every 4 hour	Y_____	N _____
Ibuprofen 200mg for pain every 4 hours	Y_____	N _____
Cough Drop 1 every 2 hours for cough or sore throat	Y_____	N _____
Tums 1 tablet daily for upset stomach	Y_____	N _____
After-Bite apply once after insect bite	Y_____	N _____
Cortaid cream or ointment once per day for minor skin irritation	Y_____	N _____
Caldryl Lotion apply once per day for minor skin irritation	Y_____	N _____
Bactine spray apply once for skin irritation/insect bites	Y_____	N _____
Bacitracin ointment once per day for cuts and abrasions	Y_____	N _____
Neosporin ointment once per day for cuts and abrasions	Y_____	N _____
Zinc Oxide cream once daily for minor skin irritation	Y_____	N _____
Foille burn ointment apply once daily	Y_____	N _____
Rhulicream apply once daily for minor skin irritation	Y_____	N _____
Chloraseptic Throat Spray one squirt once per day	Y_____	N _____
Anbesol apply once daily for tooth pain	Y_____	N _____

PARENT/GUARDIAN SIGNATURE_____DATE_____

MEDICAL PROVIDER SIGNATURE_____DATE_____

(DOCTOR, PA, NP)

<u>BOTH SIGNATURES ARE REQUIRED</u>