ST. PAUL
CATHOLIC SCHOOL
Odell, IL
300 S. West St. - 60460
815.998.2194
schooloffice@saintpaulodell.com

Date:_____

Emergency/Medical Form 2023-2024

Student's Last Name:_____ First Name:_____ Middle:_____

Birth Date:____/____/____ Gender:_____ Hair Color:_____ Eye Color:_____ Grade Level:_____

Physical Address:_____

City:_____ State:_____ Zip Code:_____

Mother's Full Name:_____

Cell Phone:_____ Work Phone:_____ Home Phone:_____

Father's Full Name:_____

Cell Phone:_____ Work Phone:_____ Home Phone:_____

Emergency Contacts - LOCAL relative or friend if parents cannot be reached -

Full Name: _____ Relation to Student:_____

Cell Phone: _____ Alternate Phone_____

Full Name: _____ Relation to Student:_____

Cell Phone: _____ Alternate Phone_____

Medical Information

Primary Doctor:_____ Last Exam:_____

Phone Number:_____ City of Practice:_____

Preferred Hospital in case of an Emergency: _____

Insurance Company: _____

Plan Number: _____ Identification Number: _____

Will your child be taking medication at school? Please list:_____

_____

_____

****Please turn over and complete the other side****

Last Name, First Name:_____

The health and well being of your child is of the utmost importance to us. Please fill out the below health questionnaire.

Has your child ever had or currently have the following? **IF YES, PLEASE EXPLAIN.**

Condition	Yes	No	Explanation/Comments
ADD/ADHD			Will student take meds at school? Please list.
Asthma			Does student need inhaler at school? What causes flare ups?
Allergies			Please list all.
Birth Defects			
Bleeding Issues			
Bone/Joint Issues			
Chicken Pox			Vaccine?
Chronic Conditions/Issues			
COVID-19			Positive Test Date: Vaccine?
Dental Issues			Last Dental Exam?
Diabetes			Need glucometer at school?
Ear/Hearing Issues			
Eye Issues			Does student require glasses? Does student wear contacts?
Fainting Spells			
Headaches (frequent)			
Heart Issues			
Hospitalizations			
Seizures			
Skin Conditions			
Speech Issues			
Surgeries			
Stomach/Digestive Issues			
Urinary Tract Infections			
Any other concerns?			

Please list any medications your child is currently taking (if not already listed above):_____

_____

_____

Authorization for Emergency Medical Treatment

This information will be kept in the possession of the school/parish. A copy will be distributed to the person in charge of each trip or athletic activity in which the student/minor participates. Should the need arise, this information will be given to the proper medical authorities.

I, _____ [parent/guardian], understand that in the case of illness or injury to my child, _____, the school/parish will try to notify me or the person I have listed as an emergency contact. In case of a medical emergency concerning my child, at a time when I or my listed emergency contact cannot be notified, I grant full power to the school/parish to 1) arrange for the transportation of my child, whether by ambulance or otherwise, to a proper facility where emergency medical treatment would normally be administered, including but not limited to, an emergency room of a hospital, a doctor's office, or a medical clinic; and 2) sign releases as may be required in order to obtain any medical or surgical treatment as is required in the judgment of medical authorities at the facility. I do hereby agree to hold harmless and indemnify the Diocese of Peoria, St. Paul School and Church, its employees and agents from and against any and all claims, demands, damages, or causes of action or injuries including reasonable attorney's fee and costs in the defense thereof, resulting from or arising out of the provision of emergency medical treatment by school personnel or by a physician and/or other medical personnel. The authorization of emergency medical treatment is valid for the length of the school year.

_____ _____

Signature of Parent/Guardian Date