

St. Joan of Arc School
School Health Information and Consent Form (2026-2027)

Student Last Name	First Name:	Middle Initial:
Address:		
County of Residence:	Gender: M F	DOB:
	Religion:	Grade:
Ethnicity:		
<input type="checkbox"/> Asian/Pacific Islander (P) <input type="checkbox"/> Black/African American (B) <input type="checkbox"/> Hispanic (H) <input type="checkbox"/> Multi-Racial (M) <input type="checkbox"/> Native American (I) <input type="checkbox"/> White/Caucasian (W)		

SECTION ONE – STUDENT EMERGENCY CONTACT INFORMATION

In the event your child becomes sick or injured and needs to be sent home or to the ER, the school office will always attempt to reach the Parent/Guardian Listed below FIRST. Secondary Contacts will be called if the parent/guardian cannot be reached. PLEASE KEEP THESE NUMBERS CURRENT!

1. Parent/Guardian Name: Check all that apply: <input type="checkbox"/> Lives with <input type="checkbox"/> Legal Guardian	ADDRESS: 	Home Number: Cell Number: Work Number:		
2. Parent/Guardian Name: Check all that apply: <input type="checkbox"/> Lives with <input type="checkbox"/> Legal Guardian	ADDRESS: 	Home Number: Cell Number: Work Number:		
Emergency Contact List	Relationship	Phone #1	Phone #2	Phone #3
1.				
2.				
3.				

Medication Policy Review

All medications (both prescription and over-the counter) MUST be sent in to school for your child. All MUST have a signed physician Medication Administration Form!!!!

Prescription medications MUST be in a prescription bottle labeled by your pharmacist.

Any OTC medication must be supplied by you. NO STOCK MEDICATIONS WILL BE AVAILABLE.

PARENTS OR ANOTHER ADULT must hand carry the medications(s) to the school office.

In EMERGENCIES requiring immediate medical attention, your child will be taken to the NEAREST hospital Emergency Room. Your signature authorizes the responsible person at the school or Extended Care (if applicable) for your child to be transported to that hospital. This also gives us permission to contact your child’s health provider if needed.

It is the responsibility of the parent/guardian to notify the school office of any changes in the student’s health status during the school year. Parent/Guardian Signature: _____ Date: _____

Thank you very much for the time to complete this form. Parent/Guardian signatures are good for the 2026-2027 School Year only. This form must be updated annually.

STUDENT HEALTH INFORMATION		Please answer the following questions pertaining to your child	
Student's Legal LAST Name		Student's Legal FIRST Name	Student's Legal MIDDLE Name
ADHD/ADD <input type="checkbox"/> Yes <input type="checkbox"/> No		Is medication needed at school?* <input type="checkbox"/> Yes <input type="checkbox"/> No	
Allergies <input type="checkbox"/> Yes <input type="checkbox"/> No		What is your child allergic to?* Please list:	
		Describe allergic reaction:	
<input type="checkbox"/> Food <input type="checkbox"/> Seasonal <input type="checkbox"/> Medication		Has your child received emergency care in the past related to allergy? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Has your child been stung by a bee? <input type="checkbox"/> Yes <input type="checkbox"/> No		Does your child have an Epi Pen? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		Will your child need an Epi Pen at school?* <input type="checkbox"/> Yes <input type="checkbox"/> No	
Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, date of last attack*:	
		Diagnosed by a doctor? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		Medication taken at home:	
		Is medication needed at school?* <input type="checkbox"/> Yes <input type="checkbox"/> No	
Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No		Does your child use insulin? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		Does your child use oral medication? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		Is medication needed at school?* <input type="checkbox"/> Yes <input type="checkbox"/> No	
		Is blood sugar monitoring needed at school?* <input type="checkbox"/> Yes <input type="checkbox"/> No	
		Is Glucagon injection needed at school?* <input type="checkbox"/> Yes <input type="checkbox"/> No	
Seizures Yes No		If yes, please describe seizure*: <input type="checkbox"/> Yes <input type="checkbox"/> No	
		Does your child take seizure medication at home? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		Is medication needed at school?* <input type="checkbox"/> Yes <input type="checkbox"/> No	
		Is your child currently under a doctor's care for seizures? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		When was his/her last seizure?	
Migraines Yes No		Is medication needed at school?* <input type="checkbox"/> Yes <input type="checkbox"/> No	
Head Injury/Concussion Yes No		Has your child been diagnosed with a concussion in the past year? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		Date of injury:	
		Is your child currently under a doctor's care for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Vision/Eye Concerns Yes No		Please list any vision concerns:	
		Does your child wear glasses or contacts? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Hearing/Ear Concerns Yes No		Does your child have a known hearing loss? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		If yes, please indicate affected ear: <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	
		Does your child wear a hearing aid? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		If yes, please indicate which ear: <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	
Heart Condition Yes No		If yes, please list condition*:	
		Does your child take medication for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		Is exercise limited?* Yes No	
Mental/Emotional Yes No		If yes, please list services that have been provided for your child*:	
Other Health Concerns Yes No		If yes, please describe*:	
		Will your child need special procedures performed at school?* <input type="checkbox"/> Yes <input type="checkbox"/> No	
		Type of health care procedure needed:	
Does your child take medications daily at home? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes," please list:			
Special Instructions for teacher and/or school nurse:			
*ADDITIONAL FORMS ARE REQUIRED TO BE COMPLETED BY A PHYSICIAN AND REVIEWED BY THE SCHOOL NURSE BEFORE ANY HEALTH ACCOMMODATIONS CAN BE MADE. SOME ACCOMMODATIONS MAY REQUIRE A DELAYED ENROLLMENT DATE			