



INFORMATION & HEALTH RECORD 2011-2012 ACADEMIC YEAR

Grade Level or Program Title: _____

Student's Full Legal Name _____ (Student)
Last First Middle Preferred Nickname

Country of Citizenship _____ Male Date of Birth _____
 Female

Student's Home Address _____
Number and Street
City State Zip Code () - Home Telephone Number

Medical Information

Food Allergies No Yes/List _____ Medication: _____

Insect Sting Allergies No Yes/List _____ Medication: _____

Medication Allergies No Yes/List _____

Is student on a regular medication regimen? No Yes - List Medications: _____

Has the student ever suffered: convulsion or seizure concussion head injury loss of consciousness

I request and give approval that in the event of injury to or assertion of illness by Student, representatives of Holy Trinity Episcopal School (School) may administer the non-prescription medications checked below (or their reasonable equivalent) to Student: Tylenol Benadryl Advil Sudafed Antacid Antibacterial ointment or spray.

Physician's Name _____ Telephone _____
Address City State Zip Code

If I or the physician above cannot readily be reached and/or if, in the sole discretion of representatives of School, time is too critical to attempt to reach me, I request and give approval for the Student to be transported to an appropriate medical facility for emergency care. I further authorize the medical facility and any attending physicians to perform any and all diagnostic procedures and/or treatments required, including blood transfusions. I agree to assume full financial responsibility for emergency transportation, treatment and other related expenses incurred on the Student's behalf. I indemnify and hold the School and its representatives harmless for any and all outcomes resulting from the administering of medications approved above, decisions to or not to transport Student, and the transportation of Student.

Insurance Information

Name of Insured _____
Last First Middle Initial
Insurance Company Certificate/Policy Number Group Number Insured's Employer
Insurance Co. Telephone Insurance Company Address

Physician's Certification

The Student named above is free of communicable diseases, has passed hearing and vision test, received immunizations required by the state of Texas, and is in sufficiently good health to participate in normal school activities. **Parents must attach a 2010-2011 hearing/vision screening, wellness examination, and immunization records for your student(s).**

Physician's Name Printed _____ Signature _____ Date _____

Contact Information

Provide two alternate emergency contacts other than father and mother. You empower these persons to make medical decisions for the Student in your absence and authorize the school to release the Student to these persons.

Table with 5 columns: Relationship, Name, Cell Phone, Work Phone, Home Phone. Rows for Father, Mother, and two blank entries.

Father's Address

Mother's Address

Email

Email

Employer

Employer

Position

Position

Employer Address

Employer Address

Telephone

Telephone

Stepfather's Name

Stepmother's Name

Address

Address

Telephone

Telephone

Email

Email

- Parental Status (check all that apply)
Student lives with

Other Information (optional) - only used for accreditation and grant writing purposes

Religious Affiliation: Baptized? May Receive Communion?

Public School District in Which You Live:

Ethnicity Information (optional) - only used for accreditation and grant writing purposes

- Check one ethnicity category: American Indian or Alaska Native, Asian or Pacific Islander, Black or African American, Hispanics of any race, Indian Subcontinent, Middle Eastern, White European or North American, Multiethnic Origin, Unknown

Holy Trinity Episcopal School values diversity and collects ethnicity information only for the purposes of statistical reporting. The school admits students of all ethnicities and does not discriminate in the administration of its educational, financial aid or other programs.

I attest that the information provided is accurate and complete, and acknowledge, agree to and approve all requests, stipulations the provisions herein.

Parent or Legal Guardian of Student

Parent or Legal Guardian of Student

Signature

Signature:

Date

Date

Print Name:

Print Name: