Department of Catholic Schools
Archdiocese of San Antonio
2718 W. Woodlawn Ave
San Antonio, TX 78228
210-734-2620 • Fax 210-734-9112
www.sacatholicschools.org

STUDENT HEALTH FORM

School Year: _____ **Grade:** _____ **Homeroom Teacher:** _____

Student's Name: _____ _____ **M / F**

Last Name First Name M.I. Date of Birth Gender

Primary Address: _____ _____

Street Address City State Zip

It is the Texas Catholic Conference of Bishops policy that every student in a Catholic School in the State of Texas be immunized against vaccine preventable diseases caused by infectious agents in accordance with the immunization schedule adopted by the Texas Department of State Health Services.

Children will be screened as set forth by the Texas Department of State Health Services for hearing, vision, scoliosis and acanthosis nigricans. The school follows the required screening schedule from the State of Texas.

WHERE CAN PARENTS/GUARDIANS BE REACHED?

Mother/Guardian Name: _____ **Primary Phone:** _____

Address if different: _____ **Secondary Phone:** _____

Work Place: _____ **Work Phone:** _____

Work Address: _____ **Email:** _____

Father/Guardian Name: _____ **Primary Phone:** _____

Address if different: _____ **Secondary Phone:** _____

Work Place: _____ **Work Phone:** _____

Work Address: _____ **Email:** _____

Please list designated persons allowed to assume temporary care of your child if you are not available. **ONLY** the designated individuals listed below will be able to pick-up your child/children from school. ***Changes or additions to this form must be made in writing.***

1) Name: _____ **Primary Phone:** _____

Address: _____ **Secondary Phone:** _____
Relationship: _____ **Work Phone:** _____

2) Name: _____ **Primary Phone:** _____

Address: _____ **Secondary Phone:** _____

Relationship: _____ **Work Phone:** _____

** You may list additional Authorized Persons to assume temporary care of your child/children on the reverse.
ONLY the designated people will be able to pick up your child/children from school.**

Student's Name: _____

3) Name: _____ **Primary Phone:** _____

Address: _____ **Secondary Phone:** _____

Relationship: _____ **Work Phone:** _____

4) Name: _____ **Primary Phone:** _____

Address: _____ **Secondary Phone:** _____

Relationship: _____ **Work Phone:** _____

*** Is any person, including mother or father, legally restrained from picking up this child?** Yes / No

If yes, please give a brief description of the restrictions in the space below:

CONDITION	Moderate	Severe	COMMENTS
Allergy - Drug/Other			
Asthma			
Accident or Illness**			
Blood Disorder			
Cardiac Disease/Problem			
Chicken Pox (**date required**)			
Congenital Deformity			
Diabetes			
Hearing Loss			
Hypertension			
Neurological Disorder			
Otitis Media (Ear Infection)			
Seizure Disorder (Epilepsy)**			
Surgery – Serious**			
Urinary Problem			
Vision Loss			
INJURIES			
Head**			
Back**			
OTHER:			

** Details required, please use COMMENTS section.

List all medications (prescription, over-the counter, and herbal) that your child takes regularly:

_____

Primary Physician's Name: _____ **Phone:** _____

Hospital Preference: _____

Dentist: _____ **Phone:** _____

In the case of accident or illness, I request the school contact me. If the school is unable to reach me, the school has permission to take whatever action they deem necessary for the health and welfare of my child in the event of an emergency. I give permission for release of information on this form for confidential use in meeting my child's health and educational needs in school.

Parent/Guardian Signature: _____ **Date:** _____

Parent/Guardian Name Printed: _____