Application

& Emergency Medical Form

STUDENT INFORMATION

NAME: _____ GENDER: _____
Last First Middle

ADDRESS: _____

_____

PHONE NUMBER: (Home)_____ (Cell)_____

SOCIAL SECURITY NUMBER: _____ DATE of BIRTH: _____

BIRTHPLACE: _____ _____ _____
City State Zip

WILL BE ENTERING GRADE: _____ LAST SCHOOL ATTENDED:_____

DATE of ENTRY to BDHS: _____ PARISH: _____

PHYSICAL DISABILITIES_____ PROHIBITED MEDICATIONS _____

If your child has been given academic modifications/accommodations in his/her previous school or has psychological education results please check here _____.

FAMILY INFORMATION

FATHER's NAME: _____ Living? Yes No At Home? Yes No

OCCUPATION: _____ EMPLOYER: _____

MOTHER's NAME: _____ Living? Yes No At Home? Yes No

OCCUPATION: _____ EMPLOYER: _____

MOTHER's Maiden Name: _____

GUARDIAN's Name(s) (if applicable) _____

TOTAL NUMBER OF CHILDREN in family: _____ Older Brothers: _____ Older Sisters: _____

Younger Brothers: _____ Younger Sisters: _____

CONTACT INFORMATION

STUDENT'S E-MAIL: _____ CELL PHONE: (_____)_____

FATHER'S E-MAIL: _____ CELL PHONE: (_____)_____

WORK PHONE: (_____)_____

MOTHER'S E-MAIL: _____ CELL PHONE: (_____)_____

WORK PHONE: (_____)_____

(Home, Cell Phone, & E-Mail information will be included in our automated information system)

EMERGENCY MEDICAL AUTHORIZATION

INSURANCE NAME **STUDENT NAME**

INSURANCE NUMBER **ADDRESS** **TELEPHONE**

PURPOSE – to enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents or guardians cannot be reached.

********** PART I OR PART II MUST BE COMPLETED **********

PART I (TO GRANT CONSENT)

In the event reasonable attempts to contact me at _____(phone #) or _____ (other parent or guardian) have been unsuccessful, I hereby give my consent for: (1) the administration of any treatment deemed necessary by Dr. _____ (preferred physician) or Dr. _____ (preferred dentist), or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to _____ (preferred hospital) or any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performing of such surgery.

Facts concerning the child's medical history including but not limited to allergies, medications being taken and any physical impairments to which a physician should be alerted: _____

_____

_____

DATE **SIGNATURE OF PARENT OR GUARDIAN**

PART II (REFUSAL TO CONSENT)

I do NOT give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take no action or to: _____

_____

DATE **SIGNATURE OF PARENT OR GUARDIAN**

MEDICAL CARE AT SCHOOL

1) Does your son or daughter take prescribed medication during school hours? _____ YES _____ NO

- **If YES please list below the name of the medication they are taking, the reason the medicine has been prescribed and the time your child is to take the medication.**

_____

_____

_____

_____

POLICY

Any prescribed medicine taken during school hours by your son or daughter must be kept in the main office. Students are not permitted to keep prescribed medicine in their lockers or carry it with them.