Bishop Flaget School

Confidential and Privileged Medical and Family History Form

I. **Family History**

Child's Name_____ Birth date_____
(Last) (First) (Middle)

Sex: M F Place of Birth _____
(County) (State) (Country)

Father	**Mother**
Name_____	Name_____
Address_____	Address_____
City, State _____	City, State _____
Telephone _____	Telephone _____
Occupation _____	Occupation _____
Age _____ Email:_____	Age _____ Email:_____

List persons who are currently living in the home:

Name	Age	Relationship

Please list two people to be contact in the event of an emergency *if the parent cannot be contacted*:

Name:_____ Phone #s:_____
Relationship:_____

Name:_____ Phone #s:_____
Relationship:_____

List of additional person(s) to whom this child can be released (name/phone/relationship):

_____

_____

List of Person(s) ***not permitted*** to pick up this child (please print):_____

_____
(please attach restraint or divorce decree papers if pertinent)

Medical History:

Family Doctor: _____Phone: _____

Address: _____

Has your child had any serious illnesses or accidents in infancy or childhood? _____Yes _____No
If yes, please explain.

_____

_____

List all medications currently being administered to your child: _____

_____

Has your child had any history or seizures (convulsions)? YES NO

If yes, please explain the date of the last seizure and the medical treatment.

_____

Do you suspect a hearing or vision loss? YES NO Explain:_____

_____

List all allergies affecting your child and/or precautions that need to be taken:_____

_____

Any Chronic Physical Problems?_____

_____

Please list all diseases your child has had:_____

_____

Has your child ever had eczema or hives? YES NO

Ever had wheezing or asthma? YES NO

Has your child had any trouble with urination? YES NO

Family Dentist:_____ Phone:_____

Address: _____

Date Last Seen:_____ Any dental issues?_____

_____

Developmental History

Were there any unusual circumstances or occurrences during pregnancy or birth?

_____

Any known birth injuries?

_____

Birthweight: _____lbs. _____ozs.

When did your child accomplish the developmental milestones?

Crawling_____ Dressing Self _____Walking _____

Talking_____ Toilet Training _____

Does your child sleep through the night? _____ Explain: _____

_____

Has your child ever attended any type of school? YES NO

Circle which one: Sunday School Head Start PreSchool

Are there any behavioral concerns you have regarding your child which you feel the school should be aware of? Please explain.

_____

_____

Statement of anything else you feel would be helpful for the school to know about your child:

_____

_____

_____

_____

Date Completed:_____

Parent/Guardian Completing Form (please print): _____

Parent/Guardian's Signature: _____

Emergency Medical Authorization

Child's Name: _____ Address:_____

Home Phone: _____ Parent's Cell/Work #: _____

Email Addresses: _____

If both parents work, please provide the phone number of the other parent: _____

(State of Ohio Revised Code Section 3313.712)

Purpose: To enable parents to authorize emergency treatment for children who become ill or injured while under school authority when parents cannot be reached.

Part I or Part II must be completed

Part I (To Grant Request)

In the event reasonable attempts to contact me or (other parent's name) _____ have been unsuccessful, I hereby give my consent for: (1) the administration of any treatment deemed necessary by (preferred physician) Dr. _____ or (preferred dentist) Dr. _____, or in the event the designated preferred practitioner is not available, by any 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 the necessity for such surgery, are obtained before surgery is performed.

Physician's phone #:_____ Dentist's Phone #:_____

Facts concern the child's medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted.

_____

_____

Date:_____ Signature of Parent/Guardian:_____

(Do not complete Part II if you completed Part I)

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 medical treatment, I wish the school authorities to take no action or to:

_____

_____

Date:_____ Signature of Parent/Guardian:_____