Cardinal Ritter High School
Health Record Form 2021-2022

Student Name: _____ Grade: _____ ☐ Male ☐ Female Date of Birth _____

Father/guardian _____ Mother/guardian _____

Yes No ☐ ☐ Custodial Parent

Yes No ☐ ☐ Custodial Parent

Primary Phone: _____ Primary Phone: _____
Work Phone: _____ Work Phone: _____
Home Phone: _____ Home Phone: _____
Cell Phone: _____ Cell Phone: _____

In case of emergency or illness if parent is unavailable, we authorize the following people to make health decisions for our child and/or pick them up from school:

1st contact: _____ 1st contact: _____
Relationship: _____ Relationship: _____
Primary Phone: _____ Primary Phone: _____
Other Phone: _____ Other Phone: _____

STUDENT HEALTH HISTORY

Please check the appropriate box for **each** item; add comments to clarify symptoms/treatments/provide additional information

Yes	No		Comments/Additional Information (add additional page if necessary)
☐	☐	Allergies List Allergens: Describe Reaction and Treatment Needed: ***Please submit medical mgmt plan from MD if Epi-pen is required for treatment***	
☐	☐	Bee Sting Reaction Describe Reaction and Treatment Needed: ***Please submit medical mgmt plan from MD if Epi-pen is required for treatment***	
☐	☐	Asthma **(please submit medical mgmt plan from MD)**	
☐	☐	Cancer	
☐	☐	Diabetes **(please submit medical mgmt plan from MD)**	
☐	☐	Hypoglycemia	
☐	☐	Eye Problems (excluding corrective lenses for vision)	
☐	☐	Ear/Hearing Problems	
☐	☐	Heart Condition/Hypertentsion	
☐	☐	Migraine/Chronic Headaches	
☐	☐	Seizures	
☐	☐	History of Concussions	
☐	☐	ADHD	
☐	☐	Mental Health Conditions (depression/anxiety/etc)	
☐	☐	Other - please list and provide additional information for each condition (attach additional page if needed)	

I authorize Cardinal Ritter to share the information on this form and all information maintained in the student health file with all teachers and staff involved in the care of my child. I grant permission for my physician and the Principal, School Nurse or other designated Cardinal Ritter staff to share any and all health information relevant to the care of my child.

Signature of parent(s)/guardian(s) _____

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ANY PARENT WISHING TO PERMIT SCHOOL STAFF TO ADMINISTER MEDICATION MUST COMPLETE APPROPRIATE SECTION ON THE BACK OF THIS FORM