SCHOOL VISIT FORM

Date of Visit:___________ Grade Visiting:_________

____
Student's last name First name Middle

____
Address Town Zip

________________________________ Male/Female(circle) DOB:_____________________________
Home Phone

In case of medical emergency, cell for Mother: ____________________________________

Father: ____________________________________

Please list friend or relative who will assume temporary care of your child if you cannot be reached:

____
Name Phone Relationship

How will your child be picked up on the day of visit?___________________________________

Known allergies for student:
(Please list all that apply____

Are there any medications that must be taken at school? (Please list)

____

Other health concerns:____

Child's Physician: ____
Phone

Choice of hospital to be used if medically expedient: ___________________________________

In the event of severe allergic reaction with life-threatening symptoms such as breathing difficulties, wheezing and other signs of impending anaphylactic shock, I give permission to the registered nurse at St. John Paul II High School to administer Adrenalin and/or Benadryl in accordance in accordance with the guidelines set forth below.

I understand that in the event of accident or serious illness the school will try to contact me. If the school is unable to reach me, I authorize the school to contact the physician named and to follow his/her instructions. If the physician cannot be reached and my child requires medical attention and/or transportation to another location for treatment, I give the school permission to make arrangements deemed necessary to secure treatment.

I hereby certify that I have read and understand the above stated procedures and duly authorize the administration of the school and/or school nurse to secure medical treatment and/or transport my child when they deem necessary.

____Parent(s)
Signature Date