

Quincy Catholic Academy
Health Registration Form 2017-2018

This form should be filled out by the child's parent or legal guardian. Return the completed form to the school nurse.

Child's Name _____ Date of Birth _____ Sex: Male Female
Grade _____ Teacher _____ Child's race/ethnicity _____
Address _____

PARENT/GUARDIAN INFORMATION

Mother/Guardian: Name _____ Email _____
Tel # (Home) _____ (Cell) _____ (Work) _____
Father/Guardian: Name _____ Email _____
Tel # (Home) _____ (Cell) _____ (Work) _____
Emergency Contacts: Name _____ Relationship _____ Tel # _____
Name _____ Relationship _____ Tel # _____

MEDICAL HISTORY

Health Concerns: Does your child have any health concerns the nurse needs to be aware of? Yes No
If YES, please describe. _____
Can your child participate in all school activities? Yes No
Allergies: Does your child have any allergies (foods, medications, environmental)? Yes No
If YES, please list allergies _____
Does your child have an EpiPen? Yes No
If YES, please send Allergy Action Plan and EpiPen to school.
Medication: Does your child currently take medications? Yes No
If YES, please list current medications _____
Past Medical History: Date of last doctor's visit _____
Date of last dental exam _____
Does your child have hearing or vision problems? Yes No
If YES, do they wear glasses? Yes No or hearing aids? Yes No
Does or has your child received professional care for any of the following?
 Mental Health >> please explain _____
 Asthma >> If selected, please send inhaler and Asthma Action Plan to school
 Diabetes Kidney Disease Orthopedic Concussion/Head Injury
 Heart Disease Seizure Other _____

MEDICAL PROVIDER INFORMATION

Primary Care Provider: Name _____ Tel # _____
Dentist: Name _____ Tel # _____
Other Provider: Name _____ Tel # _____
Health Insurance: Policy # _____ Insurance Provider _____

PARENT/GUARDIAN CONSENT

The school nurse has permission to share health information with appropriate QCA staff for my child's health and safety. Yes No
The school nurse has permission to share and receive information about my child with my child's healthcare provider. Yes No

Parent/Guardian Signature _____	Print Name _____	Date _____
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**If you have any questions or concerns
please contact the school nurse at
(617) 328-3830 or at nurse@quincycatholicacademy.org**

**CONSENT TO ADMINISTER OVER-THE-COUNTER MEDICATIONS IN SCHOOL
2017-2018**

Child's Name _____ Date of Birth _____ Grade _____ Teacher _____
Please list allergies (foods, medications, environmental): _____

The school nurse has my permission to administer the following over-the-counter medications in accordance with the doctor's standing order for Quincy Catholic Academy, prescribed by the school physician Dr. Robert Shiner. (Please check all that apply)

- Acetaminophen (Tylenol)**
- Ibuprofen (Advil)**
- Antacid Tablets (Tums)**

**Please note, only Registered Nurses may administer OTC medications in school.
If your child needs OTC medications regularly, please contact the school nurse for a medication plan.**

Parent/Guardian Signature _____	Print Name _____	Date _____
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ITEMS USED IN HEALTH OFFICE

The following items are routinely used by the school nurse to treat students as needed. Please review the list and contact your school nurse if you child has an allergy or known contraindication to any product.

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| <ul style="list-style-type: none">• Alcohol solution 70%• Vaseline ointment, Aloe-Vera gel, Aquaphor• Calamine lotion• Bacitracin, Neosporin, Triple Antibiotic Ointment• Oral gel - Anbesol/Oragel/Orasol• Soaps - hand soaps, antibacterial | <ul style="list-style-type: none">• Cough/Throat Lozenges• Hydrocortisone ointment• Hydrogen Peroxide• Bactine• Blistex• First Aid Cream |
|--|---|

..... For clinical / office use only

School nurse signature _____ Date _____ Form complete? Yes No

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