Central Catholic High School
2550 Cherry Street, Toledo, Ohio 43608-2394

SCHOOL HEALTH RECORD INFORMATION

IMMUNIZATION RECORD:

The State of Ohio law (ORC 3313.67 and 3313.671) requires specific immunizations for school attendance. A copy of the students immunization record MUST be provided for all Freshmen (9th grade) and incoming Transfer students prior to the start of school.

****Freshmen and Incoming Transfer Students: Please attach a copy of the students immunization records to this form****

Please indicate any health condition of which the school nurse or teacher should be aware:

ALLERGIES AND ASTHMA		LIST ALLERGIES AND MEDICATIONS PRESCRIBED
Allergies	☐ YES ☐ NO	
Antihistamines	☐ YES ☐ NO	
Epinephrine (EpiPen)	☐ YES ☐ NO	An emergency Allergy Action Plan must be provided for students that require epinephrine (EpiPens) for severe allergy symptoms.
Asthma	☐ YES ☐ NO	An Asthma Action Plan must be provided for students that carry an inhaler in school

HEALTH CONDITIONS		LIST MEDICATIONS PRESCRIBED OR THERAPY REQUIRED
ADD/ADHD	☐ YES ☐ NO	
ANXIETY	☐ YES ☐ NO	
DEPRESSION	☐ YES ☐ NO	
DIABETES	☐ YES ☐ NO	
HYPERTENSION	☐ YES ☐ NO	
EPILEPSY	☐ YES ☐ NO	
HEADACHE	☐ YES ☐ NO	
HEART/CARDIAC	☐ YES ☐ NO	
Neurocardiogenic SYNCOPE or POTTS	☐ YES ☐ NO	
MUSCLE/BONE	☐ YES ☐ NO	
OPERATIONS	☐ YES ☐ NO	
SCOLIOSIS	☐ YES ☐ NO	(Corrective Surgery or Brace)
SPEECH/HEARING	☐ YES ☐ NO	
VISION	☐ YES ☐ NO	Glasses: _____________ Contacts: _____________ Last Vision Exam: _________________
OTHER	☐ YES ☐ NO	
Physical Limitations	☐ YES ☐ NO	Please describe:

The nurse has permission to give my child the following over-the-counter medications for pain related to common complaints such as headache, menstrual cramps, minor illness symptoms, joint or muscle pain. My childs healthcare provider has been informed of or has recommended the use of these over-the-counter medications.

☐ YES ☐ NO Acetaminophen (Tylenol) 1-2 tablets, 325 mg per manufacturer recommendations

☐ YES ☐ NO Ibuprofen (Advil, Motrin) 1-2 tablets, 200 mg per manufacturer recommendations

______________________________	______________________________	______________
Parent/Guardian Name (Please Print)	**Parent/Guardian Signature**	**Date**

Central Catholic High School

419-255-2280 2550 Cherry Street, Toledo, Ohio 43608-2394 419-259-2848 FAX

EMERGENCY MEDICAL AUTHORIZATION

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

Student's Name	Student's Address	Student's Date of Birth
(Last)____________________ (First)____________________	(Street)____________________ (City)____________________	____________________ **Month/Day/Year** (Cell) ____________________
Parent/Guardian Name	**Parent/Guardian Address**	**Parent/Guardian Phone Number**
(Last)____________________ (First)____________________ ☐ **Mother** ☐ **Father** ☐ **Guardian**	(Street)____________________ (City)____________________ (Zip Code) ____________________	(Home) ____________________ (Cell) ____________________ (Work) ____________________
Parent/Guardian Name	**Parent/Guardian Address**	**Parent/Guardian Phone Number**
(Last)____________________ (First)____________________ ☐ **Mother** ☐ **Father** ☐ **Guardian**	(Street)____________________ (City)____________________ (Zip Code) ____________________	(Home) ____________________ (Cell) ____________________ (Work) ____________________

Person(s) to contact if parents/guardian are not available:

Name	Relationship	Phone

Acknowledgment and Agreement to Protocols for a Life-threatening Situation or Medical Emergency:

In the event of a life-threatening situation or what the school deems to be a medical emergency, I understand the school will call 911 and request an ambulance or police transport to a hospital, the location of which is at the discretion of the EMTs, for emergency treatment. I further understand the school will make every effort to contact me directly before transport.

If the situation is not life-threatening or what the school deems to be a medical emergency, but other medical attention is needed, I understand that it will be necessary to have the student picked up by a parent, guardian, or other approved designee.

____________________ ____________________________
Date **Signature of Parent or Guardian**

THIS FORM MUST BE COMPLETED AND SIGNED IN INK EACH YEAR.
*******See back of form to complete health history*******

healthrecinfoform