ST. PETER CATHOLIC SCHOOL
124 First Street
Monument, Colorado 80132

Office: 719-481-1855
Fax: 719-266-3402
petertherockschool.org

Student Health & Medical Information

If your child/ren have health concerns, please provide us with the following information so that we may respond to your child/ren's needs during school hours. This information may be shared with adults at St. Peter Catholic School on a need-to-know basis. This health care plan will be in effect for the current school year. It is your responsibility to notify the office whenever there is a change in your child/ren's health status or care.

Student Name _____ **DOB**_____

☐ My child does NOT have any health or medical concerns.

☐ My child has health concern(s): _____

_____

Allergies (Health Care Plan required): _____

_____

Respiratory (Health Care Plan required): _____

_____

PLEASE LIST ADDITIONAL CHILDREN ON THE REVERSE SIDE OF THIS FORM.

If medication is to be administered at school, please complete a Medical Authorization form to be signed by you and your physician. A Health Care Plan* may be required. Please check with the office to receive the appropriate forms.

***This Health Care Plan and any nurse delegation related to this plan are for use during regular school hours. Medication concerns outside of regular school hours need to be referred to the child/ren's parents, Poison Control or 911. If a parent can attend a before/after school activity, they will assume responsibility for the medication.**

Child/ren's Physician: _____

_____
Address Phone

Child/ren's Dentist: _____

_____
Address Phone

Hospital Preference: _____

I hereby authorize representatives of St. Peter Catholic School to take my child/ren to the above named physician or facility for medical treatment in the event of an emergency in which neither parent can be reached. If the above named physician cannot respond, I authorize any licensed physician or medical center to treat my child/ren. I realize that I am responsible for any expenses incurred during treatment. I further authorize the hospital or emergency care facility to release my child/ren to the school representative should care no longer be required.

_____ _____
Parent/Guardian Signature Date

Student Name _____ **DOB**_____

☐ My child does NOT have any health or medical concerns.

☐ My child has health concern(s): _____

_____

Allergies (Health Care Plan required): _____

_____

Respiratory (Health Care Plan required): _____

_____

Student Name _____ **DOB**_____

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☐ My child has health concern(s): _____

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