St. Patrick School
INTEGRITY•LOYALTY•COMMITMENT

Infirmary Card

Name Student: ________________________________ Doctor: ______________________

Sex: _______ Date Birth: ________ Grade: _________ Telephone: ____________________

Parent 1: _______________________________ Dentist: _____________________

Telephone: ______________ Work Place: _____________ Telephone: _____________________

Parent 2: ___________________________ Blood Type: ____________________

Telephone: _____________ Work Place: ____

Emergency Contact: ___________________ Telephone/Cel: ______________ / ____________

Is there any chronic health? Is there any physical or mental problem that could influence students academic progress? If so complete the next section.

Health Areas of Concern

Please mark with an X the areas of problem:
Asma ( ), Bronquitis ( ), Diabetes ( ), Hiperativity ( ), Heart Condition ( ), Epilepsy ( ), Throat Infections ( ), Nose Bleeding( ), Ear Infections ( ), Stomach Problems ( ), Dizziness ( ), Skin Conditions ( ), Sight Problems ( ), Kidney Problems ( ).

Is medication required on a daily basis for any of the students condition (s)?
If affirmative fill out the medication information:

Medicine

Name of Medicine: ______________

Dosage: ________________________

Times: _________________________

Specifications:

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List any Allergies to:

Medicines: ____________________

Foods: ________________________

Animals/Insects: _______________

Other: ________________________

I authorize the nurse at St. Patrick School to give the following medications to my son/daughter if necessary: Tylenol, Ibuprofen, Antiacid, Pepto Bismol, Cold medication, Benadryl, Ear drops, Eye drops.

All: ____________________________ None: ____________________________

Restricted: ____

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Parent/Tutor Signature: