



Sacred Heart School for the Arts

EMERGENCY HEALTH CARE PLAN

Medical History

Child's Name: _____

Allergic to: _____

Asthmatic: _____ Yes _____ No

Other Significant Medical Condition: _____

Medications taken including prescription medicines: _____

Does this child require the use of the Epi-Pen? _____ Yes _____ No

If, yes, does this child need for the Epi-Pen to be kept at School? _____ Yes _____ No

Does this child require the use of an Inhaler? _____ Yes _____ No

If yes, does this child need for the Inhaler to be kept at School? _____ Yes _____ No

As a general rule, all medication is kept in the School office locked in a safe place.

Emergency Medical Authorization

Sacred Heart School for the Arts reserves the right to immediately call Emergency Medical Services in the event of serious or life-threatening illness or injury. I hereby authorize the administration of any treatment deemed necessary and/or the transferal of my child to the hospital where treatment can be administered promptly. Parent or Guardian signature below authorizes Sacred Heart School for the Arts to seek emergency medical care for the child.

This authorization does not cover major surgery unless the medical opinions of two licensed physicians or dentists concurring in the necessity of such surgery are obtained before such surgery is performed.

I prefer that the following physician, dentist, and/or hospital treat my child, if possible:

Preferred Physician: _____ Phone _____

Preferred Dentist: _____ Phone _____

Preferred Hospital _____ Phone _____

Insurance Carrier: _____ Policy # _____

Parent Signature _____ Date _____
