

SEDES SAPIENTIAE SCHOOL

CLASSICAL CATHOLIC EDUCATION

ANNUAL HEALTH UPDATE AND PERMISSION-TO-TREAT FORM 2021-2022 Academic Year

NAME OF STUDENT: _____ GRADE: _____

Please complete the following Health Update:

1. Has your child had any accidents/injuries **in the last year** that required medical care? Yes _____ No _____

If yes, please explain: _____

2. Has your child had any operations **in the last year**? Yes _____ No _____ If yes, please explain: _____

3. Has your child had any serious illness or chronic condition that the Health Office needs to be aware of?

Yes _____ No _____ If yes, please explain: _____

4. Is your child on **ANY** prescription medication? Yes _____ No _____ If yes, please indicate the name of **ALL** medications whether or not they are administered during school hours. If a medication needs to be administered during school hours, the **Authorization to Administer Medication in School** form must be completed and returned to the Health Office. Medication(s): _____

5. Does your child have any pre-existing allergies or developed any allergies **in the last year**? (Ex: bee sting, latex, food, pollen, medications, etc.) Yes _____ No _____ If yes, please explain: _____

6. Has your child had any immunizations/injections **in the last year**? Yes _____ No _____

If yes, please explain: _____

Parental Consent to Treat: The law requires that parental permission and physician approval be obtained for procedures on minors. The following consent should be signed by the parents or guardians so that such procedures may be promptly carried out.

“In case of accident or serious illness, I request the school to contact me. If the school is unable to reach me, I thereby authorize the school to call the physician indicated below and to follow his/her instructions. If it is impossible to contact this physician, the school may make whatever arrangements deemed necessary.”

I give my consent for my child to be transported to and treated at a local hospital: YES _____ NO _____

Signature of Parent/Guardian

Date

NAME of Parent/Guardian (Please PRINT)

Parent/Guardian Phone #

Local Physician's Name (Please PRINT): _____

Physician's Office Phone Number: _____

Please return to the Office at Sedes Sapientiae School.

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