



SAINT CHARLES PREPARATORY SCHOOL  
ANNUAL HEALTH INFORMATION  
and  
STUDENT HANDBOOK ACKNOWLEDGMENT FORM



Name \_\_\_\_\_  
Address \_\_\_\_\_  
Home Phone \_\_\_\_\_  
Student's Private Phone \_\_\_\_\_  
Parent's Email Addresses Email #1. \_\_\_\_\_

Grade \_\_\_\_\_ Date of Birth \_\_\_\_\_  
City/State/Zip \_\_\_\_\_  
Religion \_\_\_\_\_  
Student's St. Charles ID Number \_\_\_\_\_  
Email #2. \_\_\_\_\_

Custodial Parent \_\_\_\_\_ (St. Charles is required to have on file a copy of the custodial orders)

If separated or divorced, do you wish:

- 1) Grades to be sent to both parents? (Circle One) **Yes / No**
- 2) School mailings to be sent to both parents? (Circle One) **Yes / No**
- 3) Both parents addresses and phone numbers listed in student directory? (Circle One) **Yes / No**

Father's Name \_\_\_\_\_  
Stepmother's Name \_\_\_\_\_  
Address \_\_\_\_\_  
City/State/Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_  
Work/Cell Phone \_\_\_\_\_  
Place of Employment \_\_\_\_\_

Mother's Name \_\_\_\_\_  
Stepfather's Name \_\_\_\_\_  
Address \_\_\_\_\_  
City/State/Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_  
Work Phone/Cell \_\_\_\_\_  
Place of Employment \_\_\_\_\_

Emergency Number:

Other Persons who will care for student, if parents and the emergency number listed above cannot be reached:

#1: \_\_\_\_\_ (Relationship) \_\_\_\_\_  
Home# \_\_\_\_\_ Work# \_\_\_\_\_ Cell# \_\_\_\_\_  
#2: \_\_\_\_\_ (Relationship) \_\_\_\_\_  
Home# \_\_\_\_\_ Work# \_\_\_\_\_ Cell# \_\_\_\_\_

ANY KNOWN HEALTH CONDITIONS OR PROBLEMS? Please include allergies, recent illnesses, injuries, or conditions affecting school performance. \_\_\_\_\_

Does your son have Learning Disabilities? (Circle One) **Yes / No**

Has your son been tested for Attention Deficit? (Circle One) **Yes / No**

If so, when, where, and by whom was he tested? \_\_\_\_\_

Is your son taking medication regularly? (Circle One) **Yes / No**

If so, please state the name and purpose of the medication. \_\_\_\_\_

If you wish to give permission for Tylenol tablets to be given your son, at his request, please check the following:

The nurse has permission to give Tylenol ( 1 or 2 ) tabs. (325 mg. Each), when necessary. (Circle One) **Yes / No**

Is he allergic to these? (Circle One) **Yes / No**

**The undersigned acknowledge they have received and understand this form, have read the *St. Charles Preparatory Student Handbook 2011-2012*, and agree to abide by all rules and regulations of the school:**

**Parent Signature** \_\_\_\_\_

**Date** \_\_\_\_\_

**Student Signature** \_\_\_\_\_

**Date** \_\_\_\_\_

**EMERGENCY MEDICAL AUTHORIZATION**  
(State of Ohio Revised Code Section 3313.712)

Saint Charles Preparatory School  
2010 East Broad Street  
Columbus, Ohio 43209  
614-252-6714

Student Name \_\_\_\_\_

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Home Phone # (     ) \_\_\_\_\_ Date of Birth \_\_\_\_\_

**Purpose:** To enable parents to authorize emergency treatment for sons who become ill or injured while under school authority, when parents cannot be reached.

**PART 1 OR 2 MUST BE COMPLETED**

**Part 1 (TO GRANT REQUEST)**

In the event reasonable attempts to contact me or (other parent's name) \_\_\_\_\_ have been unsuccessful (see other side of paper for phone numbers where we can be reached), I HEREBY GIVE MY CONSENT for: (1) the administration of any treatment deemed necessary by (preferred physician) Dr. \_\_\_\_\_ or (preferred dentist) Dr. \_\_\_\_\_, or in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of my son to \_\_\_\_\_ (preferred hospital) or any reasonably accessible hospital. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained before surgery is performed.

Facts concerning my son's medical history including allergies, medication being taken, and any physical impairment to which a physician should be alerted:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Parent Signature \_\_\_\_\_

Date \_\_\_\_\_

**Part 2 (REFUSAL TO CONSENT)**  
**(DO NOT COMPLETE PART 2 IF YOU COMPLETED PART 1)**

I DO NOT GIVE MY CONSENT for emergency medical treatment of my son, in the event of illness or injury requiring medical treatment. I wish the school authorities to take no action, or to \_\_\_\_\_ .

Parent Signature \_\_\_\_\_

Date \_\_\_\_\_