



ST. PETER
CATHOLIC SCHOOL

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124 First Street
Monument, Colorado 80132

Office: 719-481-1855

Fax: 719-955-0509

Website: ucsppr.org

Student Health & Medical Information

Student Name _____ DOB _____

If your child has health concerns, please provide us with the following information so that we may respond to your child's needs during school hours.

Health Concern(s): _____

Allergies (Health Care Plan required): _____

Respiratory (Health Care Plan required): _____

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.

I give permission for this information to 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. I understand that it is my responsibility to notify the office whenever there is a change in my child's health status or care.

I have read the above and my child does not have any health or medical concerns. This health care plan will be in effect for the current school year. I understand that it is my responsibility to notify the office whenever there is a change in my child's health status or care.

Parent/Guardian Signature

Date

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

Child's Physician: _____
Name Address Phone

Child's Dentist: _____
Name Address Phone

Hospital Preference: _____
Name Address Phone

I hereby authorize representatives of St. Peter Catholic School to take my child 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. 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 to the school representative should care no longer be required.

Signature _____ Date _____