

Student Clinic Card

St. John the Evangelist School

Instructions: This card must be completed by the parent or guardian and returned to the school. Please Print

Name of Student		Date of Birth	Grade
Address: Street Number & Name; City, Zip			Home Phone
Mother's Name	Work Phone	Cell Phone	
Father's Name	Work Phone	Cell Phone	
Name of Person who will assume responsibility if Parent cannot be reached:			Phone
Physician's Name			Phone
Dentist's Name			Phone
Medications (Is your child taking any medications?) Yes No. If yes, please list names of medications.			
Allergies (List any allergies your child may have)			
Other Health Problems			

In case of accident or serious illness, the school will contact the parent/guardian. If the school is unable to contact the parent/guardian or person designated above, the school will contact the physician or will make necessary arrangements for immediate treatment. Payment of fees will be assumed by the parent/guardian.

I have reviewed and understand the conditions of the clinic emergency information card.

Signature of Parent/Guardian

Date