# SAINT JOAN OF ARC SCHOOL
# BEFORE/AFTER CARE
# PROGRAM (BAC)
## 2024-2025 HEALTH HISTORY FORM

**STUDENT HEALTH HISTORY (Must be fully completed)**

**Name:_____Grade:_____**

**Child's Doctor's Name_____Phone _____**
**Child's Dentist's Name_____Phone _____**

**Allergies (Please check all that apply or NONE): Hay Fever_____Antibiotic (type)_____**
**Drugs (type)_____Poison Ivy_____ Other Plants_____**
**Insect Stings_____**

**Food Allergy [please name the food(s)]_____NONE_____**
**Other_____**
**Does child require an Epi Pen? _____Inhaler:_____**

**Please tell us what we need to know about your child's allergy(ies): _____**

_____

**Operations or Serious Injuries:**

**Date of Injury/Surgery:_____Type of Injury/Surgery_____**

**Date of Injury/Surgery:_____Type of Injury/Surgery_____**

**Disability/Chronic/Recurring Illness_____**

**Specific Activities to be Encouraged/Limited by Physician's Advice_____**

**EMERGENCY PERMISSION SLIP**

There is always a possibility that child may be injured or become seriously ill during the BEFORE/AFTER SCHOOL PROGRAM and that we may not be able to contact the parents. **Medical aid cannot be given to a child without his/her parent's consent.** In an emergency, time can be vital. Your signature on this permission slip, which is kept on file at SJA BAC, will allow for medical aid in case such an emergency occurs and we are unable to reach you immediately.

**I give permission for my child_____, grade_____, to be transported to a Hospital Emergency Room for medical aid in the case of extreme emergency, provided I cannot be contacted when the emergency occurs.**

HOSPITAL PREFERENCE: _____

Please indicate which parent should be called first in an emergency: Mother_____Father_____

Father's Signature_____Date_____

Mother's Signature_____Date_____

**Please notify SJA BAC, in writing, of any change of information given on this form as soon as possible.**
**Thank You!**