BISHOP STANG HIGH SCHOOL

Visiting Student Permission and Health Form

Complete this form to give permission for your child to visit Bishop Stang High School.

Visit Date: _____

Student Name: _____ **Date of Birth:** _____ **Grade**: _____

Parent/Guardian Name: _____ **Cell Phone:** _____

Emergency Contact Name: _____ **Cell Phone:** _____

Alternative Child Pick Up Name: _____ **Cell Phone:** _____

Medical History: (Please check all that apply. Provide additional information as needed.)

- ☐ Asthma
- ☐ Allergies (Please list: _____)
- ☐ Diabetes
- ☐ Seizures
- ☐ Other (Please describe: _____)

Additional health information we need to know for your child's visit: _____

_____

_____

Does your child have an Epi-Pen? **YES** ☐ **NO** ☐

Does your child have an inhaler? **YES** ☐ **NO** ☐

Does your child routinely take medications? **YES** ☐ **NO** ☐ (If yes, please list: _____

_____

If your child requires an EpiPen, inhaler or medication, special documentation is required, along with providing the device or medication. Contact Mrs. Laura Duarte, R.N., lduarte@bishopstang.org, to get the paperwork and discuss this process.

Participation in School Activities: I authorize the above named student to fully participate in all school activities, which may include physical education. **YES** ☐ **NO** ☐

Authorization and Consent for Medical Treatment for the following date: Understanding that my child may need emergency treatment while visiting ***Bishop Stang High School*** on the date listed above, I authorize the school, through the nurse or other qualified person, to administer first aid or other medical treatment, as deemed best under the circumstances. I consent for my child to receive such treatment. I understand that the school will attempt to notify me, or the emergency contact on this form, in the event of an emergency requiring immediate medical care for my child. If the school is unable to notify me, in case of a serious injury/illness, the school has my permission to arrange transportation to and treatment at the nearest emergency room.

_____ _____

Signature of Parent Guardian **Date**