St. John the Evangelist School **Student Clinic Card**	School Year:	Grade:
Student Name: (Last, First)	Date of Birth	
Address:	Home Phone:	
Mother's Name: Mothers Email:	Work Phone Cell Phone:	
Father's Name: Father's Email:	Work Phone: Cell Phone:	
Name of Person and Phone Who Will Assume Responsibility if Parent CANNOT be reached:		
Physician Name and Phone:		
Dentist Name and Phone:		
Please List any ALLERGIES and REACTIONS your child may have: (please use back for additional space) Does Allergy require EpiPen or AuviQ? YES or NO		
Please list ANY medications your child is taking: (please include dose, time, route, and reason for taking medication): (please use back for additional space)		
Other Medical Conditions: (please explain and please use back for additional space)		
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 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 Student Clinic Card

Parent/Guardian Signature _____ Date _____

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