



**PADUA**<sup>®</sup>  
FRANCISCAN  
HIGH SCHOOL

**MEDICAL QUESTIONNAIRE AND EMERGENCY MEDICAL AUTHORIZATION**

FAMILY/GUARDIAN MUST COMPLETE THIS FORM YEARLY (both sides)

**Must be returned by March 15, 2026**

Date: \_\_\_\_\_ Grade Entering: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Student's Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Students Address: \_\_\_\_\_

City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Mother: \_\_\_\_\_

Daytime Phone: \_\_\_\_\_

Father: \_\_\_\_\_

Daytime Phone: \_\_\_\_\_

Emergency Contact (if parent/guardian is unavailable): \_\_\_\_\_

Address: \_\_\_\_\_

Daytime Phone: \_\_\_\_\_

Student lives with: \_\_\_\_\_

**MEDICAL HISTORY**

Please check off the following conditions this student has been diagnosed with:

\_\_\_\_\_ Allergies: Food: \_\_\_\_\_ Medication: \_\_\_\_\_ Bee: \_\_\_\_\_ Seasonal: \_\_\_\_\_

\_\_\_\_\_ Asthma: Inhaler? YES \_\_\_\_\_ (see below) NO \_\_\_\_\_

Student will carry inhaler at school \_\_\_\_\_ Student will not carry inhaler at school \_\_\_\_\_

\_\_\_\_\_ Diabetes: \_\_\_\_\_ **(Diabetes Care Plan is required)**

\_\_\_\_\_ Seizures: \_\_\_\_\_ **(Seizures Care Plan is required)**

\_\_\_\_\_ Heart Condition: \_\_\_\_\_

\_\_\_\_\_ Gastrointestinal: \_\_\_\_\_

\_\_\_\_\_ Migraines: \_\_\_\_\_ (A physician statement is recommended)

\_\_\_\_\_ Scoliosis: \_\_\_\_\_

\_\_\_\_\_ Vision/Hearing Impairment: \_\_\_\_\_

\_\_\_\_\_ Other: \_\_\_\_\_

Additional space to explain any conditions checked above: \_\_\_\_\_

Please explain any additional health problems, limitations or special medical concerns that the school should be aware of: \_\_\_\_\_

## MEDICATIONS

List medications this student is currently taking, dose, frequency and medical condition.

Medication: \_\_\_\_\_ Dose: \_\_\_\_\_ Frequency: \_\_\_\_\_ Condition: \_\_\_\_\_

Medication: \_\_\_\_\_ Dose: \_\_\_\_\_ Frequency: \_\_\_\_\_ Condition: \_\_\_\_\_

Medication: \_\_\_\_\_ Dose: \_\_\_\_\_ Frequency: \_\_\_\_\_ Condition: \_\_\_\_\_

**Will this student be taking medication at school?** YES \_\_\_\_\_ NO \_\_\_\_\_

NOTE: All students taking prescription or over-the-counter medication at school **MUST** have on file a Medication Administration Form. Forms are available on the Padua Franciscan High School Website. If needed, please contact the school clinic for further instruction.

*Medical information shared with the school may be shared with school officials who have a legitimate educational interest.*

## PART I OR PART II MUST BE COMPLETED

### EMERGENCY MEDICAL AUTHORIZATION

#### PART I (TO GRANT CONSENT)

I hereby give consent for the following medical care providers and local hospital to be called:

Doctor: \_\_\_\_\_ Tel: \_\_\_\_\_

Dentist: \_\_\_\_\_ Tel: \_\_\_\_\_

Medical Specialist: \_\_\_\_\_ Tel: \_\_\_\_\_

Local Hospital: \_\_\_\_\_ Tel: \_\_\_\_\_

Dentist: \_\_\_\_\_

In the event reasonable attempts to contact me at \_\_\_\_\_ (tel #) or \_\_\_\_\_ (other parent) at \_\_\_\_\_ (tel #) have been unsuccessful, I hereby give my consent for: (1) the administration of any treatment deemed necessary by Dr. \_\_\_\_\_ (preferred doctor) at \_\_\_\_\_ (tel #), or in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to \_\_\_\_\_ (preferred hospital) or any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of 2 other licensed physicians or dentists, concur-ring in the necessity for such surgery, are obtained before the surgery is performed.

Facts concerning the child's medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted: \_\_\_\_\_

Date:	Signature of Parent/Guardian:
-------	-------------------------------

## DO NOT COMPLETE PART II IF YOU HAVE COMPLETED PART I

#### PART II (REFUSAL OF CONSENT)

I DO NOT GIVE MY CONSENT for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take no action or to: \_\_\_\_\_

Date:	Signature of Parent/Guardian:
-------	-------------------------------