



SAINT JOAN OF ARC SCHOOL
BEFORE/AFTER CARE
PROGRAM (BAC)
2025-2026 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 _____ 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!