





## MEDICAL INFORMATION

Name of student's physician \_\_\_\_\_ Phone \_\_\_\_\_

Medical History (circle):	YES	NO	Explanation	Is student currently taking medication on a regular basis? If yes, please specify:
High blood pressure	YES	NO		
Heart or blood vessel disease	YES	NO		
Liver or kidney problems	YES	NO		
Diabetes	YES	NO		
Epilepsy	YES	NO		
Respiratory difficulties	YES	NO		
Sensory disturbances	YES	NO		
Arthritis or joint problems	YES	NO		
Special diet restrictions	YES	NO		
Metal implants	YES	NO		
Pacemaker	YES	NO		
Visual Problems	YES	NO		
Hearing problems	YES	NO		
Unusual reaction to heat/cold	YES	NO		
Allergies	YES	NO		
Asthma	YES	NO		
Hypoglycemia	YES	NO		
ADD/ADHD	YES	NO		

Please attach any other medical information of which you feel the school should be aware.

Refer to SJA Handbook for medication policy.

*On behalf of my student, I do hereby consent to any and all medical and surgical treatments including anesthesia and operations, which may be deemed advisable by his/her physicians and surgeons. The intention hereof being to grant authority to administer and to perform all and singularly any examinations, treatments, anesthetics, operations, and diagnostic procedures which may now or during the course of the student's care be deemed advisable and necessary. This form will be used only in case of emergency and after every reasonable effort is made to contact parent/guardian prior to admitting the student for necessary treatment. Consent is also given for release of information for insurance purposes, and I submit authorization for responsible third party to pay directly to the treating hospital, insurance benefits due me for services rendered.*

*I give authorization/consent for the disclosure of the student's protected health information as a student at St. Joseph Academy. I understand that my student's protected health information is protected by the federal regulations under either the Health Information Portability and Accountability Act (HIPAA) or the Family Educational Rights and Privacy Act of 1974 (the Buckley Amendment) and may not be disclosed without either parent/legal guardian authorization under HIPAA or consent under the Buckley Amendment. I, the parent/legal guardian, understand that once information is disclosed per authorization or consent, the information is subject to re-disclosure and may no longer be protected by HIPAA and/or the Buckley Amendment. I, the parent/legal guardian, understand that I may revoke this authorization/consent at any time by written notification to the Principal, but if I do, it will not have any effect on the actions St. Joseph Academy officials took in reliance on this authorization/consent prior to receiving the revocation. This authorization/consent expires at the close of the 2010-2011 academic year.*

Insurance Co. \_\_\_\_\_ Policy Number \_\_\_\_\_

Parent/Guardian Name (print) \_\_\_\_\_ Parent/Guardian Signature X \_\_\_\_\_

Witness Name (print) \_\_\_\_\_ Witness Signature X \_\_\_\_\_

Signatures are required for consent to medical treatment.

## EMERGENCY INFORMATION

When the school is unable to reach a parent/guardian in the event of an illness or emergency, the persons listed below are authorized to pick up or drop off my child, \_\_\_\_\_, and these persons may sanction medical attention, leaving campus for illness or any other purpose, participation in student activity, and these persons may assume temporary care of my child.

X \_\_\_\_\_  
Signature of Parent/guardian

Name \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

Address \_\_\_\_\_

Home phone \_\_\_\_\_ Relationship \_\_\_\_\_

Home phone \_\_\_\_\_ Relationship \_\_\_\_\_

Business phone \_\_\_\_\_ Ext \_\_\_\_\_

Business Phone \_\_\_\_\_ Ext \_\_\_\_\_

Beeper \_\_\_\_\_ Cellular \_\_\_\_\_

Beeper \_\_\_\_\_ Cellular \_\_\_\_\_

## CONDITIONS AND TERMS OF AGREEMENT

We, the undersigned, agree to comply with all current policies, rules, and regulations of St. Joseph Academy and any amendments or changes made to said policies, rules and regulations at St. Joseph Academy's sole discretion. We hereby authorize the Diocese of St. Augustine to use and reproduce all photography, illustrations and/or other works of art, written copy, and other creative services for hire, perpetually. We attest that all information is complete, factually correct, and honestly presented. Deletion or misrepresentation of information is cause for immediate dismissal.

Student's signature **X** \_\_\_\_\_ Date \_\_\_\_\_

Father / Guardian's signature **X** \_\_\_\_\_ Date \_\_\_\_\_

Mother / Guardian's Signature **X** \_\_\_\_\_ Date \_\_\_\_\_

## FINANCIAL RESPONSIBILITY

I assume financial responsibility for the total cost of \_\_\_\_\_'s Tuition and  
**Student's full name**

Fees for the entire 2008-2009 school year and understand that all tuition and fees paid to St. Joseph Academy are non-refundable. I agree to pay tuition according to the published schedule for the school year (monthly payments must be made in order to maintain student status).

Name \_\_\_\_\_ Relationship to Student \_\_\_\_\_

Address for tuition statements \_\_\_\_\_  
Street City State Zip

Home Phone (\_\_\_\_) \_\_\_\_\_ Signature X \_\_\_\_\_

Business Phone (\_\_\_\_) \_\_\_\_\_

## PAYMENT METHOD

Check One:

\_\_\_\_ F.A.C.T.S. (10 automatic withdrawals May through February) F.A.C.T.S. charge for this service: \$38.00 per year.

**OR**

\_\_\_\_ Annual Payment before May 1<sup>st</sup>, 2010.

### FOR OFFICE USE ONLY

Catholic Tuition Rate

Non-Catholic Tuition Rate

Date Registration Paid \_\_\_\_\_

Account # \_\_\_\_\_

Entered School System \_\_\_\_\_

Entered Course Selection \_\_\_\_\_