Emergency and Health Information 2019-2020

Student's Name _____ Sex M F Grade Entering _____
Last First M.I.

Address _____ Date of Birth ___/___/_____

City _____ State _____ Zip Code _____ Home Phone _____

Mother's Name _____ Father's Name _____

Home Phone _____ Home Phone _____

Cell Phone _____ Cell Phone _____

Employer _____ Employer _____

Work Phone _____ Work Phone _____

Siblings: Name _____ Grade _____ Student Lives with: Both Parents Mother Father

Name _____ Grade _____ Guardian/Other _____

Name _____ Grade _____

Student's Physician _____ Phone _____

Hospital Preference _____ Phone _____

Student's Dentist _____ Phone _____

EMERGENCY CONTACTS/AUTHORIZED PICK UP

List the names of two (2) adults who will assume responsibility in the event you can't be reached/who are allowed to pick up your student(s).

1. Name _____ Phone _____

Relationship: Non-custodial Parent Grandparent Aunt/Uncle Family Friend

2. Name _____ Phone _____

Relationship: Non-custodial Parent Grandparent Aunt/Uncle Family Friend

STUDENT HEALTH HISTORY: Does the student have any of the following? If so, please describe.

Allergies ☐ Yes ☐ No List _____

Has the allergy required emergency treatment in the past? Describe _____

Bee Sting Allergy ☐ Yes ☐ No Describe the reaction _____

Difficulty breathing? ☐ Yes ☐ No Emergency Medication? ☐ Yes ☐ No

Asthma ☐ Yes ☐ No Triggered by _____ Medication _____

Diabetes ☐ Yes ☐ No Insulin ☐ Yes ☐ No Hypoglycemic ☐ Yes ☐ No Regimen _____

Epilepsy/seizures ☐ Yes ☐ No Describe seizures _____

Date of last seizure _____ Medication _____

Heart Condition ☐ Yes ☐ No Describe _____ Physical Restrictions _____

Bone/Joint problems ☐ Yes ☐ No Describe _____ Physical Restrictions _____

Blood Disorders ☐ Yes ☐ No ☐ Hemophilia ☐ Sickle Cell ☐ Other _____

ADD/ADHD ☐ Yes ☐ No Medication _____

Autism/Asperger's Syndrome ☐ Yes ☐ No Medication _____

Please check the appropriate boxes regarding health concerns that pertain to the student

Eyes ☐ Glasses ☐ Contacts ☐ Lazy Eye

Ears ☐ Frequent infections ☐ Tubes ☐ Hearing Aids ☐ Hearing Difficulties Explain _____

Other ☐ Nose Bleeds ☐ Speech Problems ☐ Anxiety ☐ ADHD ☐ Skin ☐ Dental ☐ Neurological ☐ Stomach

Daily prescription medication at home ☐ Yes ☐ No

Daily prescription medication at school ☐ Yes ☐ No *(If given at school, a parent & physician signature sheet must be signed - available in the office)*

List medications: _____

Please list any serious illnesses, injuries and/or surgeries: When _____ What for _____

When _____ What for _____

PARENT/GUARDIAN SIGNATURE IS REQUIRED ON REVERSE SIDE

Permission for Discretionary Medication 2019-2020

Student's Name_____
Last First M.I.

I authorize the nurse or designated person to provide for my child with appropriate medication according to appropriate dosage for age. I waive any claims I might have against the school, its employees and agents arising out of the administration of said medication. In addition, I agree to release, hold harmless, and indemnify the School and its employees from any and all claims, damages, causes of action of injury incurred or resulting from the administration or attempts of said medication.

☐ Advil ☐ Tylenol ☐ Do not give any medication Child's current age _____ Child's current weight _____

In cases of emergency, when neither parent or family physician can be reached, my child may be taken to the hospital if deemed necessary by the school and/or para-medicals. ☐ Yes ☐ No

Signature of Parent/Guardian_____Date_____

DATE	TIME	NOTES	INIT.

Christian Life Schools admits students of any race, color and national or ethnic origin.

Revised 1/16/19