Emergency and Health Information 2021-2022

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_____

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 2021-2022

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 1/21/21