# K-8 EMERGENCY INFORMATION FORM

## Section A

**____/____/20____**
**Date Entering C.C.S.**

_____ M___ F___ ____/____/_____ _____
Student's Name (Last, First, Middle) Sex Birth date Grade

_____ M___ F___ ____/____/_____ _____
Student's Name (Last, First, Middle) Sex Birth date Grade

_____ (_____)_____
Student's Street Address City Zip Code Home Telephone

Student lives primarily with: Father _____ Mother _____ Other (relationship): _____

_____ _____ _____ (__)_____ (___)_____
Father's/Guardian's Name Employer Business Phone Cell Phone

_____ _____ (__)_____ (___)_____
Mother's/Guardian's Name Employer Business Phone Cell Phone

_____ _____
***PRIMARY*** E-mail Address Preschool Siblings Enrolled at CCS Name(s)

In event of illness/emergency and the parent or guardian cannot be reached, list in **priority** order who we may contact and release your student to:

1) Name:_____ Relation to student: _____ Phone: ( ) _____

2) Name:_____ Relation to student: _____ Phone: ( ) _____

3) Name:_____ Relation to student: _____ Phone: ( ) _____

OUT OF TOWN CONTACT (in case of disaster): Name/number:_____

## Section B

### AUTHORIZATION TO CONSENT TO TREATMENT OF MINOR

I/We, the parent(s) of _____, do hereby authorize Covenant Christian School (CCS) as agent(s) for the undersigned to consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general supervision of any physician and surgeon licensed under the provisions of the Medicine Practice Act on the medical staff of a licensed hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital.

It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required, but is given in advance to provide authority and power on the part of the aforesaid physician in the exercise of his best judgment may deem advisable. Authorization is hereby given to Covenant Christian School personnel to administer First-Aid Treatment during school activities or to call the Paramedics or Rescue Squad as deemed necessary.

This authorization shall remain effective until the last school day of the **20_____- 20**_____ school year, unless sooner revoked in writing delivered to CCS.

_____ ____/____/____ _____ ____/____/____
Father's Signature Date Mother's Signature Date

**Do you have medical insurance** to cover cost of any injuries incurred at school? Yes_____ No_____

**Insurance Carrier**:_____ **Policy #:** _____

**DOCTOR:** _____ **Phone: (_____)**_____

**DENTIST:** _____ **Phone: (_____)**_____

**PLEASE FILL IN THE FOLLOWING INFORMATION:**

1. Does this student have a health problem? Yes_____ No _____ If yes, please specify (circle): Allergy, Asthma, Diabetes, Wears Glasses, Hearing problem, Bee Sting sensitivity, Epilepsy or Other:_____
2. Does this student take daily medication at home? Yes____ No____ If yes, name & dosage:_____
3. Will the student take daily medication at school? Yes____ No____ If yes, name & dosage:_____
   (Written authorization to dispense medicine at school must be on file in school office.)
4. List any drug allergies or sensitivity:_____ _____ _____
5. Within the past six (6) months has student taken:
   Circle if Yes: Cortisone, ACTH, Anticoagulants, Tranquilizers, Hypertensive (High blood pressure medicines)
6. Has the student ever received treatment for Asthma, Rheumatism, or Rheumatic Fever? YES ____ NO ____
   Explain: _____