

K-8 EMERGENCY INFORMATION FORM

Section A

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

Student's Name (Last, First, Middle) M F Sex ____/____/____ Birth date ____ Grade

Student's Name (Last, First, Middle) M F Sex ____/____/____ Birth date ____ Grade

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

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

Father's or Guardian's Name Employer Business Phone Cell Phone

Mother's or 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: _____