Family Christian Academy

EMERGENCY AND MEDICAL INFORMATION

To be completed by Parent/Guardian only. Use blue pen. School Year _____

_____ _____ _____ _____
Student's Legal Last Name | Student's Legal First Name | MI | Nickname

_____/_____/_____ _____ _____ ☐ Male ☐ Female
Birthdate | Age | Grade

_____ _____
Address/City/State/Zip | Home Phone

_____ _____
Mailing Address (If different from residence above) | Cell Phone

_____ _____ _____
Father's Name (Guardian) | Place of Employment | Work Phone

_____ _____ _____
Mother's Name (Guardian) | Place of Employment | Work Phone

STUDENT LIVES WITH: (check one) ☐ Both Parents (same address) ☐ Mother ☐ Father ☐ Other_____

CUSTODY: _____
(List any special custody problems. Appropriate legal documentation must be on file in a student's cumulative folder)

_____ _____ _____
Primary Physician Name | Address | Phone Number

_____ _____ _____
Hospital Name | Address | Phone Number

_____ _____ _____ _____
Health Insurance Policy | Policy Number | Group Number | Policy Holder

HEALTH CONDITIONS:

- ☐ Allergy to insects – specify severity below
- ☐ Allergy to medicine – specify severity below
- ☐ Allergy to food – specify severity below
- ☐ Allergy to other – specify severity below
- ☐ EpiPen
- ☐ Anemia
- ☐ Arthritis – specify below
- ☐ Asthma
- ☐ Cancer – specify below
- ☐ Cerebral Palsy
- ☐ Diabetes (Type _____)
- ☐ Drug Dependency – specific below
- ☐ Ear Infections / Repeated
- ☐ Epilepsy/Seizures
  Date of last seizure _____
- ☐ Gastrointestinal Condition
- ☐ Headaches – specify below
- ☐ Hearing impairment
- ☐ Hemophilia
- ☐ Heart Disease/Murmur – specify below
- ☐ Hernia – specify below
- ☐ High blood pressure
- ☐ Hyperactivity (ADD;ADHD)
- ☐ Hypoglycemia
- ☐ Kidney Disease
- ☐ Leukemia
- ☐ Muscular Dystrophy
- ☐ Motor Impairment
- ☐ Nosebleeds
- ☐ Physical Impairment
- ☐ Psychological Problems – specify below
- ☐ Scoliosis
- ☐ Sickle Cell Disease
- ☐ Sickle Cell Trait
- ☐ Speech Impairment
- ☐ Transplant – specify below
- ☐ Urological Condition(s)
- ☐ Visual Correction Glasses
- ☐ Visual Corrective Contacts
- ☐ Visual Problems – specify below
- ☐ Other – specify below

Specify severity of health conditions/ specify restriction on activity and any accommodations needed while at school *(may use other side of this form if additional space is needed)* _____
_____
_____

List all medications (plus dosage, time, etc.) that the student takes AT HOME/OR SCHOOL: _____
_____

Child Pickup/Emergencies: Should my child become ill or injured during the school and the school be unable to contact me, I hereby give the school permission to contact one or more of the following persons to pick up my child at school and care for my child during my absence. ***(Must be at least 18 years of age.)***

_____ _____ _____ _____ _____ _____
(1) Name | Relationship | Telephone | (3) Name | Relationship | Telephone

_____ _____ _____ _____ _____ _____
(2) Name | Relationship | Telephone | (4) Name | Relationship | Telephone

In case of an emergency where immediate medical treatment is deemed necessary by the sponsors and/or representatives of Family Christian Academy, and in the event that I/we cannot be contacted in a timely manner, I/we give my/our permission and consent for first aid, para-medical, emergency room, clinic, or doctor's office treatment necessary for the physical welfare of my/our child/children. I/we agree to bear the financial responsibility of such treatment. I/we will not hold Family Christian Academy or any of its representatives or sponsors responsible for the results of such medical treatment, accidents, or injuries sustained during any scheduled activity.

_____ _____ _____ _____
Father/Guardian Signature | Date | Mother/Guardian Signature | Date

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