EMERGENCY AND ILLNESS INFORMATION

PCS
PARKVIEW CHRISTIAN SCHOOL

DATE:

STUDENT FULL NAME:

	FIRST	*MIDDLE*	*LAST*

GRADE:	DATE OF BIRTH:	AGE:	

FATHER'S FULL NAME:

	FIRST	*MIDDLE*	*LAST*

MOTHER'S FULL NAME:

	FIRST	*MIDDLE*	*LAST*

ADDRESS: GA

STREET	*CITY*	*STATE*	*ZIP CODE*

PHONE NUMBERS

HOME:	MOTHER CELL:	FATHER CELL:

EMAIL ADDRESSES

MOTHER:	FATHER:

PLACE OF EMPLOYMENT

FATHER:	WORK PHONE:
MOTHER:	WORK PHONE:

EMERGENCY CONTACT

NAME:	PHONE:	RELATIONSHIP TO STUDENT:
ADDRESS:		

PHYSICIAN INFORMATION

DOCTOR:	PHONE:
ADDRESS:	
DENTIST:	PHONE:
ADDRESS:	

HEALTH CONDITIONS

DOES YOUR CHILD HAVE ANY HEALTH CONDITIONS THAT WE SHOULD BE AWARE OF? YES NO

If yes, please indicate:

_____ ALLERGIES _____ ASTHMA _____ ARTHRITIS _____ BEE/BUG STING ALLERGY _____ SEIZURES

_____ DIABETES _____ FRACTURES _____ GLASSES/CONTACTS _____ HEART IRREGULARITIES _____ INTERNAL IRREGULARITIES

_____ KIDNEY/BLADDER _____ PHYSICAL HANDICAP _____ INHALER _____ EPI PEN _____ DEAFNESS

OTHER: (PLEASE DESCRIBE) _____

_____

TURN OVER TO COMPLETE.

NOTE: If you checked allergies and your child uses an inhaler, please give specific directions for its use (how often, how many puffs, adult supervision).

CONSENT FOR MEDICAL TREATMENT

STUDENT FULL NAME:			
	FIRST	*MIDDLE*	*LAST*
INSURANCE COMPANY:		POLICY #:	
		GROUP/MEMBER #:	

OVER-THE-COUNTER MEDICATIONS

DO YOU AUTHORIZE THE SCHOOL TO ISSUE THESE MEDICATIONS IF NECESSARY?

_____ACETAMINOPHEN (TYLENOL) _____IBUPROFEN _____COUGH DROPS _____BENADRYL
_____TUMS _____PRESCRIBED EPI PEN

In the event that my child(ren) become(s) ill or is injured while under school supervision, I approve the school authorities taking the following steps in the following order:

1. Contact a parent or legal guardian of the student and follow his or her instructions.

2. In the event of an emergency when neither parent can be reached immediately, the school authorities are hereby authorized to use their best judgment in contacting a properly licensed physician or in transporting my child to the nearest hospital for consultation and/or treatment. Such transporting to be done either by school provided transportation or, if school officials deem it wise, by ambulance.

If, in the opinion of a properly licensed and practicing physician, my child needs medical or surgical services which require my consent being supplied, and I cannot be reached, I hereby authorize, appoint, and empower the principal, teacher, or his/her designated representative to furnish on my behalf such written or oral authorization as may be so required.

I release the principal, teacher, or his/her designated representative and Parkview Christian School from any liability which might arise from the giving of such authorization, it being my desire that my child be furnished with such medical or surgical services as soon as possible after the need arises.

_____
Parent or Guardian Signature

_____ **SUBMIT FORM BY CLICKING ON THE BOX**
Date