Student Emergency and Illness Information



Date:							
Student Name:							
	Last			First		Middle	
Date of Birth:	of Birth: A		Age: Gra		Grade:		
Address:							
	Street				City	State	Zip

Parent or Guardian Information

Father's Name:							
Last	First	Middle					
Phone Number:	Email:						
Place of Employment:		Work Phone:					

Mother's Name:						
Last	First	Middle				
Phone Number:	Email:					
Place of Employment:		Work Phone:				

Emergency Contacts (other than parents)

Emergency Contact #1		
	Name	
	Relation	Phone
Emergency Contact #2		
	Name	
	Relation	Phone
Emergency Contact #3		
	Name	
	Relation	Phone
Emergency Contact #4		
	Name	
	Relation	Phone

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Physician Information					
Physician Name:	Phone:				
Address:					

Dentist Information					
Dentist Name:	Phone:				
Address:					

			Child's Health	n Information				
Does your child wear glasses/contacts:			Yes / No					
Please	indicate if your c	hild has any of the follo	owing health cond	litions, and provide	e any additional ir	nformation in the are	a below:	
Allergies	Antibiotics/	Meds Reactions	s Arthritis Asthma Bee/Bug Sting Reaction			ting Reaction	Blood Pressure	
Deafness	Diabetes	Digestive Issues	Fainting	Food Se	d Sensitivities Heada		nes/Migraines	
Heart Condition	Inhaler*	Kidney/Bladder	Physical	Handicap	ndicap Seizures Skin condition		Other	
dditional Informa	ation:							
	-							
-								

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Consent for Medical Treatment

-						
Date:						
Student Na	me:					
	Last		First		Middle	
Insurance (Company:			Policy #:		
				Group/Mem	iber #:	
				-		
		Over-th	e-Counter Medici	ines		
Do you auth	orize the school to administer the fo	ollowing media	cines, if necessary	?		
		-	-			
	Acetaminophen (Tylenol)		Cough Drops		Prescriped Epi Pen	
	Benadrvl		Ibuprofen		Tums	

In the event that my child(ren) become(s) ill or injured while under school supervision, I approve the school authorities to contact a parent or emergency contact (as listed on the Student Emergency and Illness Information form) and follow his or her instructions.

In the event of an emergency when neither parent can be immediately reached, I hereby authorize the school authorities 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 may be done 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 such written or oral authorization on my behalf as it may be 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, ir being my desire that my child be furnished with such medical or surgical services as soon as possible after the need arises.

Parent/Guardian Signature

Date

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