LIFE CHRISTIAN

MEDICAL HISTORY / EMERGENCY CONSENT FORM

2007-2008 SCHOOL YEAR

STUDENT INFORMATION

Name: _____ Sex: ☐ Male ☐ Female
Last First Middle

Address: _____
Street City Zip

Age: _____ Birth date: _____ Grade Entering: _____ Lives with: ☐Both parents ☐Father ☐Mother ☐Guardian ☐Other (explain)

Father/Stepfather/Guardian's Name: _____

Address: (if different from student) _____ Home Phone: _____

_____ Work Phone: _____

Cell/Pager #: _____

Mother/Stepmother/Guardian's Name: _____

Address: (if different from student) _____ Home Phone: _____

_____ Work Phone: _____

Cell/Pager #: _____

EMERGENCY INFORMATION

_____
Doctor's Name Phone Number Preferred Emergency Care Facility

Names of people to be called if student is injured or becomes ill at school. List in the order they are to be called:

Name	Phone Number	Relationship to Student

Daycare Provider/Sitter: _____ Phone: _____

☐ Allergies (meds or other) _____ ☐ Date of last tetanus booster _____

☐ Asthma _____ ☐ Other _____

Medications being taken _____

CONSENT FOR HOSPITAL ADMISSION AND/OR PHYSICIAN'S CARE

Medical and Surgical Consent

I, the undersigned, hereby consent to all medical and surgical treatment by the attending physician and to the administration for performance of all examinations, administering of medicine, treatments, anesthetics, operations, x-rays, or other procedures which may be deemed necessary during the stay at this medical facility for _____ (student's name).

Financial Agreement

I hereby agree to accept responsibility for any financial indebtedness incurred during the hospitalization. I agree to pay for all necessary services at the current rate and in case of collection, pay reasonable attorney's fees and collection expenses.

In the event your student is on campus after 3:15 PM and enters the after-school program, list those people who have permission to pick up your student (name and phone):

_____ _____

_____ _____

I have read the above consent form and understand and agree to its content.

Parent Signature: _____ **Date:** _____

Parent Signature: _____ **Date:** _____

Revision 11/30/06

MEDICAL HISTORY – ***This side is confidential information seen only by the school nurse.***

_____

Student Name | Date of Birth /Age | Today's Date

Date of last physical exam: _____

Does your child have now or previously had any of the following? If YES, explain briefly on line provided.

	YES	NO	
Allergies to medication	☐	☐	List:_____
Other allergies	☐	☐	List:_____
Frequent headaches	☐	☐	_____
Convulsions/seizures	☐	☐	_____
Hearing impairment	☐	☐	_____
Visual impairment	☐	☐	_____Date of last eye exam: _____
Frequent ear infections	☐	☐	_____
Asthma	☐	☐	_____
Hay fever	☐	☐	_____
Chronic bronchitis	☐	☐	_____
Sinus problems	☐	☐	_____
Heart abnormality	☐	☐	_____
Frequent stomach aches	☐	☐	_____
Frequent constipation	☐	☐	_____
Frequent diarrhea	☐	☐	_____
Kidney disease	☐	☐	_____
Blood disease	☐	☐	_____
Frequent nosebleeds	☐	☐	_____
Diabetes	☐	☐	on insulin?_____
Hypoglycemia	☐	☐	_____
Thyroid disease	☐	☐	_____
Arthritis	☐	☐	_____
Orthopedic injuries	☐	☐	_____
Skin problems	☐	☐	_____
ADD	☐	☐	_____
ADHD	☐	☐	_____
Emotional problems	☐	☐	_____

Any other health problems or physical challenges which make participation difficult in classroom or physical activity:_____

_____

_____

List any medications being taken: _____

_____

Does your son/daughter have any special needs or problems that should be known to better care for and meet his/her needs? _____

_____

Do you give permission for the school nurse to give Tylenol or Motrin if it is necessary? Yes ☐ No ☐

Girls only:

Age when periods started _____

Any menstrual problems _____