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EMERGENCY CONSENT FORM / MEDICAL HISTORY
2012-2013 SCHOOL YEAR

STUDENT INFORMATION

Name: ____ Gender: ☐Male ☐Female
First Middle Last

Address: ____
Street City Zip

Age: ________ Birth date: ____________________ Grade Entering: _________ Lives with: ☐Both parents ☐Father ☐Mother ☐Guardian ☐Host ☐Other

Have you previously attended Life Christian Academy? ☐ Yes ☐ No If yes, what year? ____________________

Father/Stepfather/Guardian/Host Name (circle one): ______________________________

Address (if different from student): ______________________________ Home Phone: ____________________

______________________________ Work Phone: ____________________

E-Mail Address: ______________________________ Cell / Pager: ____________________

Mother/Stepmother/Guardian/Host Name (circle one): ______________________________

Address (if different from student): ______________________________ Home Phone: ____________________

______________________________ Work Phone: ____________________

E-Mail Address: ______________________________ Cell / Pager: ____________________

EMERGENCY INFORMATION - ***ALL INFORMATION MUST BE COMPLETED***

____
Doctor's Name Phone Number Preferred Emergency Care Facility

List names of people to be called if student is injured or becomes ill at school. In the event your student is on campus after 3:15 pm and enters our After School Care Program, also list people who have permission to pick up your student after school and/or from the After School Care Program. List in the order they are to be called.

Name	Phone Number	Home/Work/Cell	Relationship to Student

Daycare Provider/Sitter: ______________________________ Phone: ____________________

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

☐ Asthma ____________________ ☐ Other ____________________

Current 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.

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

Parent/Guardian/Host Signature: ______________________________ **Date:** ____________________

Parent/Guardian/Host Signature: ______________________________ **Date:** ____________________

(OVER)

STUDENT MEDICAL HISTORY

____

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

Date of last physical exam: ____________________________ **Date of last dental check up:** ______________________

Doctor's Name: ______________________________________ **Dentist's Name:** _________________________________

Doctor's Phone Number: ______________________________ **Dentist's Phone Number:** _________________________

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:____ Epi-pen? __Yes __ No
Frequent headaches	☐	☐	____
Convulsions/seizures	☐	☐	____________________________________ Date of last seizure: ____________
Hearing impairment	☐	☐	____
Visual impairment	☐	☐	___________________________________ Date of last eye exam: ___________
Frequent ear infections	☐	☐	____
Asthma	☐	☐	Inhaler? ☐ Yes ☐ No Triggers: ______________________________________
Hay fever	☐	☐	____
Chronic bronchitis	☐	☐	____
Sinus problems	☐	☐	____
Heart abnormality	☐	☐	____
Frequent stomach aches	☐	☐	____
Frequent constipation	☐	☐	____
Frequent diarrhea	☐	☐	____
Kidney disease	☐	☐	____
Blood disease	☐	☐	____
Frequent nosebleeds	☐	☐	____
Diabetes	☐	☐	Insulin pump? ☐ Yes ☐ No ____
Hypoglycemia	☐	☐	____
Thyroid disease	☐	☐	____
Arthritis	☐	☐	____
Orthopedic injuries	☐	☐	____
Skin problems	☐	☐	____
ADD / ADHS (circle one)	☐	☐	Age when diagnosed _________ Medications? ☐ Yes ☐ No
Emotional problems	☐	☐	Please list: ____
			____

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

____

____

List any medications being taken: ____

____

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

____

____

Does your student use any assistive devices (e.g. glasses, hearing aides, braces, etc.)? Yes ☐ No ☐

If yes, please list: ____

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

Do you prefer a courtesy call prior to dispensing medication? Yes ☐ No ☐

Do you give permission for your student to use hand sanitizer? Yes ☐ No ☐

Girls only: Age when periods started _________

Any menstrual problems____