

# EAST BAY CHRISTIAN SCHOOL

## 2017 – 2018 MEDICAL AND EMERGENCY INFORMATION

STUDENT INFORMATION					
Student's First Name:	Middle:	Last:	Suffix:	Birth Date: / /	
Child's Address:		City:	State:	ZIP Code:	
Child's Physician:	Physician's Phone #:	Physician's Address:		Preferred Hospital:	
Child's Allergies:		Current on immunizations? <input type="checkbox"/> Yes <input type="checkbox"/> No		Religious or Medical Exemption? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Does your child regularly take medications? <input type="checkbox"/> Yes <input type="checkbox"/> No		Does your child have asthma? <input type="checkbox"/> Yes <input type="checkbox"/> No		History of Seizures? <input type="checkbox"/> Yes <input type="checkbox"/> No	
				Wear contact lenses or glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Additional Health Problems:					

PARENT/GUARDIAN INFORMATION				
Father's Name:	Emergency Phone #:	Employment:	Emergency Contact? <input type="checkbox"/> Yes <input type="checkbox"/> No	OK to pick up? <input type="checkbox"/> Yes <input type="checkbox"/> No
Mother's Name:	Emergency Phone #:	Employment:	Emergency Contact? <input type="checkbox"/> Yes <input type="checkbox"/> No	OK to pick up? <input type="checkbox"/> Yes <input type="checkbox"/> No
In case of emergency, who should be contacted first? <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Other:				
Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	Policy Holder's Name:	Insurance Company:	Policy Number:	Insurance Company Address:

EMERGENCY CONTACTS				
If a need arises for my child to be picked up from school and I cannot be reached, I authorize school personnel to call any of the following persons to pick up my child. (Please list emergency contacts in the order you would like them to be contacted.)				
Contact Name:	Relationship:	Phone:	Emergency Contact? <input type="checkbox"/> Yes <input type="checkbox"/> No	OK to pick up? <input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT		
If my child (full name), _____, should become ill or injured at East Bay Christian School (EBCS), I understand that the school will: (1) Attempt to contact me immediately and/or (2) Contact the person(s) I have designated if I cannot be reached.		
Should EBCS be unable to reach me and/pr the person(s) designated, if the nature of the illness is time sensitive and first requires immediate summoning of medical personnel, they are authorized to contact my child's physician and/or arrange for immediate medical treatment.		
The physician and/or medical facility are authorized to administer emergency medical treatment necessary to ensure the health and safety of my child.		
I will accept full responsibility for payment of Emergency transportation and Medical Service rendered.		
_____ Parent/Guardian Signature	_____ Relationship	_____ Date
Sworn to and subscribed before me this _____, day of _____, 20____ My commission expires: _____		
_____ Notary Public, State of Florida – at Large		
____ Who is personally known to me OR ____ Who has/have produced identification: _____		