EAST BAY CHRISTIAN SCHOOL

2018 – 2019 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? ❑ Yes ❑ No	Religious or Medical Exemption? ❑ Yes ❑ No	Date of last tetanus:

Does your child regularly take medications?	Does your child have asthma?	History of Seizures?	Wear contact lenses or glasses?
❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No

Additional Health Problems:

PARENT/GUARDIAN INFORMATION

Father's Name:	Emergency Phone #:	Employment:	Emergency Contact? ❑ Yes ❑ No	OK to pick up? ❑ Yes ❑ No

Mother's Name:	Emergency Phone #:	Employment:	Emergency Contact? ❑ Yes ❑ No	OK to pick up? ❑ Yes ❑ No

In case of emergency, who should be contacted first? ❑ Father ❑ Mother ❑ Other:

Insurance? ❑ Yes ❑ 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?	OK to pick up?
			❑ Yes ❑ No	❑ Yes ❑ No
			❑ Yes ❑ No	❑ Yes ❑ No
			❑ Yes ❑ No	❑ Yes ❑ 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: _____