



STUDENT INFORMATION

Last First Middle DOB Sex

FATHER'S CONTACT INFORMATION

Name Phone Number

MOTHER'S CONTACT INFORMATION

Name Phone Number

LEGAL GUARDIAN'S CONTACT INFORMATION

Name Phone Number

EMERGENCY CONTACT INFORMATION

Name Phone Number Relationship

DOCTOR'S CONTACT INFORMATION

Physician Name Phone Number

MEDICAL HISTORY

Is your child allergic to any medications? ____ If yes, please list: _____

Does your child have any allergies? ____ If yes, please list: _____

Does your child have any physical problems? ____ If yes, please explain _____

Does your child have any emotional problems? ____ If yes, please explain: _____



Does your child take any medications on a regular basis? _____ If yes, please list: _____

Does your child take any doctor prescribed medication? _____ If yes, please explain _____

Please place a check by the medical conditions your child has had:

- | | | | | |
|----------------------------------|--------------------------------------|-----------------------------------|------------------------------------|--------------------------------|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Other |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Mumps | <input type="checkbox"/> Rubella | <input type="checkbox"/> Seizures | <input type="checkbox"/> Other |

Please place a check by any of the following items that are true of your child:

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Adopted | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Excessive Fears |
| <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Speech Difficulty | <input type="checkbox"/> Frequent Headaches |
| <input type="checkbox"/> Nose Bleeds | <input type="checkbox"/> Sucks Thumb | <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Overly Shy |
| <input type="checkbox"/> Hearing Difficulty | <input type="checkbox"/> Poor Vision | <input type="checkbox"/> Tires Easily | <input type="checkbox"/> Temper Tantrums |
| <input type="checkbox"/> Other _____ | | | |
| <input type="checkbox"/> Other _____ | | | |

Any student demonstrating symptoms of a communicable illness must be excluded from classes until the student is well. A written Doctor's release will be required for the student to return to classes. Please assist us in this matter for the health and well-being of our student body.

MEDICATION

If your child needs to take medicine of any kind, it must be stored in the school office and will be administered by school staff. The medication must be given to a staff member, not a student, with instructions on dosage and procedure. You must provide means for administration; we do not provide such items. A permission slip must be filled out allowing your child to take medicine at school. All medicine must be in the original container (s).

Emergency Medical Authorization/Liability Release

The above name child is presently attending Grace Christian Academy. He/she has the following physical or medical limitations, including allergies and prohibited medicine. _____



Verification of Hospitalization Insurance for Child:

Insurance company: _____ Policy I. D. # _____

I hereby authorize and give implied consent for Grace Christian Academy's staff to employ a licensed physician on my behalf for the emergency treatment of my child, in connection with any injury, accident or illness suffered or sustained while involved in a school activity or while on school property. Said authorization and consent for emergency treatment includes hospitalization and surgical procedures recommended by physician. I understand that every reasonable effort will be made to notify me in case of such an emergency. I do hereby release and hold harmless Grace Christian Academy from any and all medical or hospital expense resulting from any type of accident or injury occurring to my child while involved in any school activity on or off campus.

Father's Signature Date

Mother's Signature Date

Guardian's Signature Date