State Line Christian School 20___ – 20___ School Year

Emergency Medical Information

Child's Name

/ / M F
Date of Birth Age Grade Sex

Parent's/Guardian's Name

( ) ( )
Home Phone Cell Phone

Home Address (Street, City, State & ZIP Code)

( )
Work Phone, Name of Workplace, Shift

Parent's/Guardian's Name

( ) ( )
Home Phone Cell Phone

( )
Work Phone, Name of Workplace, Shift

E-mail address

Alternative Emergency Contacts

Primary Emergency Contact (Name & Relationship)

( ) ( )
Home Phone Cell Phone

Home Address (Street, City, State & ZIP Code)

( )
Work Phone, Name of Workplace, Shift

Secondary Emergency Contact (Name & Relationship)

( ) ( )
Home Phone Cell Phone

Home Address (Street, City, State & ZIP Code)

( )
Work Phone, Name of Workplace, Shift

Medical Information

Hospital/Clinic Preference

Physician's Name

Phone Number

Dentist's Name

Phone Number

Insurance Company, Policy Number

Allergies/Special Health Considerations

In case of accident, injury, illness or other emergency, I/we authorize all medical, dental and surgical treatment, X-ray, laboratory, anesthesia, and other medical and/or hospital procedures as may be performed or prescribed by the attending physician, dentist and/or paramedics for my child as a result of any school or school-related activity. Additionally, in such cases, I/we waive my right to informed consent of treatment. This waiver applies only in the event that neither parent/guardian can be reached after conscientious effort on behalf of the school staff and/or in the case of an emergency.

I/we understand that should any of the above information change, it is my/our responsibility to notify the school office immediately in writing.

Parent's/Guardian's Signature

Date

Parent's/Guardian's Signature

Date