

## Emergency Contact and Medical Information 2007-08

		M	F	
<b>Student Last Name</b>	<b>First Name</b>	<b>Date of Birth</b>	<b>Sex</b>	<b>Grade</b>
<b>Father/Guardian's Name</b>		<b>Mother/Guardian's Name</b>		
( )	( )	( )	( )	
<b>Home Phone</b>	<b>Work Phone</b>	<b>Home Phone</b>	<b>Work Phone</b>	
( )	( )	( )	( )	
<b>Cell Phone</b>	<b>Other</b>	<b>Cell Phone</b>	<b>Other</b>	
<input type="checkbox"/> Cell Phone may be published in Parent Handbook		<input type="checkbox"/> Cell Phone may be published in Parent Handbook		
<input type="checkbox"/> Email may be published in Parent Handbook		<input type="checkbox"/> Email may be published in Parent Handbook		
e-mail		e-mail		
Address		Address		
City, ST ZIP Code		City, ST ZIP Code		

### Carpool/Emergency List

Calvary Christian School is authorized to release my child to any of the following at carpool or in the event of an emergency or disaster:

Name	Phone	Name	Phone
Name	Phone	Name	Phone
Name	Phone	Name	Phone

### Alternative Emergency Contacts (If Different from Above)

<b>Primary Emergency Contact</b>		<b>Secondary Emergency Contact</b>	
( )	( )	( )	( )
<b>Home Phone</b>	<b>Work Phone</b>	<b>Home Phone</b>	<b>Work Phone</b>

### Out of State Contacts

Name	Phone	Name	Phone
	( )		( )

### Special Instructions


Office Use Only
_____
Recorded

## Medical Information 2007-08

**STUDENT NAME:**

**GRADE:**

I authorize the School nurse or personnel to administer the following medications (check all that apply):

Advil/ Ibuprofen/Motrin     Tylenol/Acetaminophen     Benadryl

Other Medications (Please List):

---

---

---

---

---

Hospital/Clinic Preference

Physician's Name

Phone Number

Insurance Company

Policy Number

**ALLERGIES**     **NO KNOWN ALLERGY**     Food     Medication     Other

**(Please List and Describe Treatment)**

---

---

---

---

**Medical Conditions**

---

---

**Other Emergency Instructions**

---

---

---

I authorize all medical and surgical treatment, X-ray, laboratory, anesthesia, and other medical and/or hospital procedures as may be performed or prescribed by the attending physician and/or paramedics for my child and waive my right to informed consent of treatment. This waiver applies only in the event that neither parent/guardian can be reached in the case of an emergency.

Parent's/Guardian's Signature

Date

Office Use Only

Recorded