Student Emergency and Medical Record Form

School Year _____

Student Name:_____

Emergency Contacts: Please list 3 people we may contact in case of emergency and to whom the student may be released if unable to contact parents/guardians.

Name Contact Number Relationship to student

_____

_____

_____

Doctor Information

Name of Doctor:_____

Address and Phone number:_____

_____

Health Information

Please check all that apply:

____Asthma	____Severe ADD/ADHD	____Blood Disorder	____Cancer
____Cerebral Palsy	____Chicken Pox	____Chronic Fatigue Syndrome	____Cystic Fibrosis
____Diabetes	____Dental Problems	____Chronic earaches	___Eating Disorder
____Emotional Disorder	____Genetic Disorder	____Hearing Problems	____Tubes in Ears

____Heart Problems (No Restrictions) ____Heart Problems w/Restrictions (Please Explain:_____

_____)

____Hemophilia	____Hypoglycemia	____Kidney/Urinary Tract Disorders	____Measles
____Migraine	____Mumps	____Muscular Dystrophy	____Neurological Disorder
____Nosebleeds	____Rubella	____ Skin Condition	____Tuberculosis

Are all required immunizations up to date for Student?_____

Does your child have allergies? If yes, please explain:_____

_____

What medication(s) is your child currently taking:_____

_____

Medication Note: Please note that all medication, including over the counter and prescribed, given during the school day must have a Request for Administration of Medication form (or the equivalent) completed and signed by the parents/guardians. Students are not allowed to carry medications including acetaminophen, aspirin, ibuprofen, etc. during the school day. Exceptions are contingent upon written parental/guardian approval. Please see to it that your child understands this policy.

Does your child have frequent colds?_____

Does your child wear glasses/contacts? If yes, please give reason:_____

Does your child have any illness or disorder that requires special attention? Explain:_____

_____

_____

Are there any special procedures we should follow in case of any emergency with your child?

_____

_____

PARENTAL AUTHORIZATION OF CONSENT FOR TREATMENT OF MINOR INJURIES

Terms(please initial each statement):

_____*I/We the undersigned do authorize Madison Hills Christian School (MHCS) consent to any emergency procedures such as x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by a licensed physician and surgeon on the medical staff of any hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital.

_____*It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required, but is given to provide authority and power on the part of MHCS to give specific consent to any and all such diagnosis, treatment and hospital care which the aforementioned physician in the exercise of his/her best judgement may deem advisable.

____*These authorizations shall remain in effect for the duration of enrollment at this school, unless sooner revoked in writing delivered to MHCS office.

Parent/Guardian Signature (Please specify relationship):

_____ Date_____

_____ Date _____