GASTON CHRISTIAN SCHOOL

Medical Information/Emergency Release Form

Student's legal name. _____ **Prefers to be called** _____

Home phone:_____ Date of birth ____ /____ /____ **Grade** _____ **Gender** (please circle): ☐ ☐

Address._____ City _____ State _____ Zip Code _____

Parent information:

Mother:_____work_____cell_____

Father:_____work_____cell_____

Step-parent: _____work_____cell_____

	Name	Phone
Pediatrician/primary care provider		
Dentist		

Insurance Company:_____

Policy number_____Phone_____

Emergency contact who will assume responsibility if parent cannot be reached:

Name: home cell

Name: home cell

Date of last tetanus shot: _____

(In case of accident or serious illness, the school will contact the parent/guardian. If the school is unable to contact the parent/guardian or person designated above, the school will make necessary arrangements for immediate treatment. Payment of any fees will be assumed by the parent/guardian.)

I hereby give my consent to any hospital and/or licensed physician or authorized provider to administer necessary emergency treatment to my child in the event such treatment is imperative and I cannot be contacted.

Parent/guardian signature: _____ Date _____

Date received _____

Revised 11/26/12

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Name _____

Medical History

Please indicate below (X) if your student has any of the following, and describe any treatments/medications, or special considerations:

- ☐ Asthma (worsened by exercise?☐☐ (*Inhaler?☐☐
- ☐ Allergies (list all)_____(*EpiPen?☐☐
- ☐ Cardiac Issues
- ☐ Diabetes
- ☐ Gastrointestinal Issues
- ☐ Hearing Issues
- ☐ Kidney/Bladder Issues
- ☐ Migraines
- ☐ Orthopedic Issues
- ☐ Seizures
- ☐ Vision Issues (glasses/contacts/other _____)
- ☐ Other (list:_____)

***If your child requires having an inhaler and/or EpiPen at school, please have your physician complete the authorization form/treatment plan; these can be found on the website or obtained from the school nurse.**

Surgical history: Type(s)_____Year(s)_____

Disabilities or restrictions: _____

Monitoring devices or medical equipment to be used while at school? _____

Medications your student takes regularly: _____

Any other information about your child that would be helpful for the school nurse to know:

_____

No medications (over the counter or prescription) will be administered by the school nurse, other school personnel, or self-administered by the student without the written authorization of a parent and physician/authorized provider. All prescription medications must be brought to school in the original container with the student's name and prescription information on the label.

All over-the-counter medication dosages will be administered according to the manufacturer's recommendations on the label unless otherwise indicated by a physician. Generic substitutions may be used for non-prescription medications listed. These forms will also be the authorized form used for off campus activities, including overnight trips.

Parent/guardian signature_____ Date_____

Date received _____

Revised 11/26/12