Christ Episcopal School

EMERGENCY FORM 2017-2018

Student name_____ **Home phone**_____ **Birth date**_____ **Entering grade**___
Last, First

Home address_____

PARENT/GUARDIAN 1

Name_____

Home phone_____

Work phone_____

Cell phone_____

Email_____

PARENT/GUARDIAN 2

Name_____

Home phone_____

Work phone_____

Cell phone_____

Email_____

ALTERNATIVE EMERGENCY CONTACT

Name_____ Relationship to student_____

Home phone_____ Work phone_____ Cell phone_____

Student's physician name_____Phone_____

Date of your child's last tetanus shot_____

COMPLETE THE FOLLOWING ITEMS, AS APPROPRIATE, IF YOUR CHILD HAS A CONDITION(S) WHICH MIGHT REQUIRE EMERGENCY MEDICAL CARE.

Medical condition(s)_____

Allergies/Reactions_____

Signs/Symptoms to look for_____

If signs/symptoms appear, do this_____

To prevent incidents, do this_____

Medications currently being taken by your child_____

IN EMERGENCIES REQUIRING IMMEDIATE MEDICAL ATTENTION, YOUR CHILD WILL BE TAKEN TO THE NEAREST HOSPITAL EMERGENCY ROOM. YOUR SIGNATURE AUTHORIZES CHRIST EPISCOPAL SCHOOL PERSONNEL TO HAVE YOUR CHILD TRANSPORTED TO THAT HOSPITAL.

Signature of Parent/Guardian_____ **Date**_____

1. Name of person authorized to pick up child daily_____

Relationship to child_____ Address_____

2. Name of person authorized to pick up child daily_____

Relationship to child_____ Address_____

Christ Episcopal School

STUDENT MEDICAL HISTORY 2017-2018

Student name_____ **Home phone**_____ **Birth date**_____ **Entering grade**_____
Last, First

PLEASE ANSWER THE FOLLOWING QUESTIONS AND EXPLAIN "YES" ANSWERS BELOW. PLEASE RESPOND TO ALL QUESTIONS.

1. Does your child have allergies? If so, please circle type: Yes No
   Food Insects Pollen Seasonal Medications Animals Other
2. Has your child ever been prescribed an Epi-pen? Yes No
3. Does your child have asthma? Yes No
4. If your child has asthma, is an inhaler or other medication currently prescribed to control it? Yes No
5. Is your child currently taking a prescription medication or over the counter medication on a regular basis? Yes No
   Note: If any medication (prescription or over the counter) will be administered at school (routinely or as needed), the Parent's Request to Administer Medication Form must be submitted to the school.
6. Does your child have a heart condition? Yes No
7. Has your child ever had a seizure? Yes No
8. Does your child wear glasses or contact lenses? Yes No
9. Does your child have problems with hearing? Yes No
10. Are there any physical or mental health topics to share with the health technician or homeroom teacher? Yes No

EXPLAIN ALL "YES" ANSWERS HERE (INCLUDE RELEVANT DATES),
AND PLEASE NOTE ANY OTHER INFORMATION YOU WISH THE HEALTH TECHNICIAN AND HOMEROOM TEACHER TO BE AWARE OF.

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(This information is considered confidential and will be treated with due discretion. However, when deemed in the best interest of the student, this information may be shared with persons appointed by the Head of School.)

Important: If your child has any significant medical issue, you must call the school office (301-424-6550) to schedule a meeting with your child's teacher during the week before school. This provides the opportunity to assure that the school has all information and/or medication necessary for your child's well being.

Parent signature_____ **Date**_____