Cornerstone Christian Academy
Academics • Faith • Character

Medical Information and Emergency Care

Name _____ Age_____ Grade _____

Phone _____ DOB_____ Gender_____

Home Address_____ City_____ State____ Zip_____

Mother/Guardian Name_____ Father/Guardian Name_____

Mother/Guardian Cell_____ Father/Guardian Cell_____

Mother/Guardian Work Phone_____ Father/Guardian Work Phone_____

Emergency contact if parent/guardian not available:

Name_____ Relationship_____ Phone_____

Name_____ Relationship_____ Phone_____

Person(s) to whom child may be released:

Name_____ Phone_____ Relationship_____

Name_____ Phone_____ Relationship_____

Name_____ Phone_____ Relationship_____

Student's Physician_____ Phone_____

Student's Dentist_____ Phone_____

Hospital to which student should be taken in case of emergency _____

Allergies: None___ Seasonal___ Food___ Sting (severe)___ Latex___ Allergy to medication_____

Foods and ingredients the student needs to avoid _____

If the student is prone to **severe allergic reactions, please complete the Allergy Action Plan form (available in the office).*
***If the student has food allergies/intolerances, please provide a few "safe snacks" in a labeled bag to be kept at school.*

OVER →

Medical conditions: Asthma ____ Diabetes ____ Epilepsy ____ Heart Problems ____ Recurring Illness ____

Other_____ Vision: Glasses_____ Contacts_____ Color blind_____

Is child on prescribed medication (including inhaler)? Yes ____ No____
**If child uses an inhaler, please send one to be kept at school in the office.*

If yes, please give name of medications and reason_____
**Any prescription meds to be given at school will require a parent Request for Prescription Medication Administration and a Physician Statement of Need (found in the Parent/Student Handbook).*

Specific needs, activity restrictions, academic needs or modifications_____

_____

Insurance Company_____ Phone_____

Name of Policy Holder_____ Policy Number_____ Group Number_____

Please initial below which of the following may **NOT** be administered as needed to your child:

Triple Antibiotic Ointment _____ Hydrocortisone Cream_____ Children's Benadryl _____ Cough drops _____
Children's Tylenol_____ Children's Ibuprofen _____ Calamine lotion _____ Sore Throat Spray _____
Children's Pepto-Bismol_____ Other_____

The information on this form is in effect for the current school year. Any changes to this information must be submitted to the office in writing, including if my student may be released to any person other than those listed above.

Parent/Guardian Signature _____ Date _____

School Year: _____