

STUDENT EMERGENCY FORM

STUDENT NAME _____
Last Name Nickname

Advisor _____

Grade _____

_____ Birth date Age _____

Social Security # _____

_____ Student Street Address Home Phone Number _____

_____ City, State, Zip

ALLERGIES: No YES _____
If YES, please list

List any long-term medications(s) currently taken (Ritalin or Ritalin-type, hypo-allergenic, prescription of any type with indefinite time frame)

_____ Physician's Name

_____ Physician's Phone Number

_____ Dentist's Name

_____ Dentist's Phone Number

_____ Parent name (or 1 st contact)	_____ Daytime Contact Location & Phone Number	
_____ Cell Phone Number or alternate numbers	_____	
_____ Parent name (or 2 nd contact)	_____ Daytime Contact Location & Phone Number	
_____ Cell Phone Number or alternate numbers	_____	
_____ Other contact name/relationship	_____ Daytime Contact Number	_____ Cell Phone

_____ Insurance Company (not Agent)

_____ Phone number of Insurance Company

_____ Insurance Policy Number

_____ Hospital preference

In the event of a **medical emergency** while my child is in the care of CCES, the School Director or his appointed representative has the authority to take whatever steps are necessary to assure prompt medical attention (either in a doctor's office, dentist's office or a hospital).

_____ Date

_____ Parent/Guardian signature

(OVER)

Student Medication Release Form

I, as parent/legal guardian of _____, do hereby give permission for my child to receive medication dispensed according to my directives from the Middle School Director or his appointed representative.

I understand that any **prescribed medication** taken over an extended length of time must be brought to the Administrative Office in its original container and must be clearly marked with my child's name and instructions for proper dispensation. **Short term prescriptions also,** (antibiotics, etc.) must be brought to the Administrative Office in its original container and must be clearly marked with my child's name and instructions for proper dispensation. **All medications MUST be brought to the Administrative Office by a parent.**

I further agree to release and hold harmless Christ Church Episcopal School, its officers, directors, agents, faculty, and staff from and against any claims, actions or causes of action for damages or personal injuries of any nature whatsoever arising out of or related to my child's receipt of said medication. Should my child sustain or incur any illness as a result of receipt or omission of said medication, I understand that every effort will be made to contact me.

Does your child have any medical conditions, or physical limitations, of which school personnel should be aware? Please explain below.

I acknowledge that I have read and understand this Agreement.

Parent/Guardian signature

Date

I give permission to the School Director or his appointed representative to administer the following medication(s) to my child only as necessary. Please check each:

Advil/Motrin/ibuprofen

Tylenol/acetaminophen

Antacid

Cough drops/throat lozenges

Parent/Guardian signature

Date

(OVER)