

# EMERGENCY INFORMATION 2019-2020

## (PLEASE USE BLACK INK)

Current email address: \_\_\_\_\_

	K	1	2	3	4	5	6
Student's Name (Last, First, Middle)	Sex	Birth Date				Grade Entering	
Student's Address	Street	City	Zip	Home Phone	Cell Number		
Father's Name ( ) In Home	Employer			Business Phone	Business Cell Number		
Mother's Name ( ) In Home	Employer			Business Phone	Business Cell Number		
Step-Parent ( ) In Home	Employer			Business Phone	Business Cell Number		
Name of Doctor						Phone	

Does this student have a health problem? Yes ( ) No ( ) If yes, please specify: allergy, asthma, wears glasses, hearing problems, diabetes, epilepsy, bee sting sensitive, rheumatic fever, prosthesis, or other: \_\_\_\_\_

Does the student take daily medication at home? Yes ( ) No ( ) If yes, give name and dosage \_\_\_\_\_

Does the student take daily medication at school? Yes ( ) No ( ) If yes, give name and dosage \_\_\_\_\_

Other students at CCCA & Grade Levels

(1) _____	Name	Grade Level
(2) _____	Name	Grade Level
(3) _____	Name	Grade Level

Name two people with whom your child could be left if unable to contact parent of child (local please):

Name	Relationship	Phone	Cell Number
Name	Relationship	Phone	Cell Number

### AUTHORIZATION FOR TREATMENT OF A MINOR

I/We the parents of \_\_\_\_\_ do hereby authorize Calvary Chapel Christian Academy as agent(s) for the undersigned to consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general supervision of any physician and surgeon licensed under the provisions of the Medicine Practice Act on the medical staff of a licensed 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 in advance to provide authority and power on the part of the aforesaid agents to give a specific consent to any and all such diagnosis treatment or hospital care which the aforesaid physician in the exercise of his best judgment may deem advisable. Authorization is hereby given to Calvary Chapel Christian Academy personnel to administer First-Aid Treatment during activities or to call the Paramedics or Rescue Squad, as deemed necessary pursuant to the provisions of section 25.8 of the Civil Code of the State of California.

Father's Signature	Date	Mother's Signature	Date
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### PLEASE PROVIDE THE FOLLOWING INFORMATION

- Allergies and sensitivities: Is there a history of skin or other untoward reaction or sickness following injection or oral administration of:
 

Penicillin or other antibiotics	( ) Yes ( ) No	What _____
Morphine, Codeine, Demerol or other narcotics	( ) Yes ( ) No	What _____
Novocaine or other anesthetics	( ) Yes ( ) No	What _____
Aspirin, Emperin or other pain remedies	( ) Yes ( ) No	What _____
Sulfa Drugs	( ) Yes ( ) No	What _____
Tetanus Antitoxin or other serums	( ) Yes ( ) No	What _____
Adhesive tape	( ) Yes ( ) No	What _____
Iodine or Merthiolate	( ) Yes ( ) No	What _____
Any other drug or medication	( ) Yes ( ) No	What _____
FOOD ALLERGIES	( ) Yes ( ) No	What _____
Special Problems	( ) Yes ( ) No	What _____
- Drugs taken recently: Has the student taken, within the past six (6) months: (Circle if yes) Cortisone, ACTH, Anticoagulants, Tranquilizers, Hypotensives (High blood pressure medicines).
- Has your child received treatment for Asthma, Rheumatism, Rheumatic Fever, Sugar Diabetes, Heart Disease, or Seizure Disorder? ( ) Yes ( ) No