EMERGENCY INFORMATION 2017-2018
(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

PLEASE PROVIDE THE FOLLOWING INFORMATION

1. 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 ____________

2. 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).
3. Has your child received treatment for Asthma, Rheumatism, Rheumatic Fever, Sugar Diabetes, Heart Disease, or Seizure Disorder? ( ) Yes ( ) No