ST. JOHN'S
Episcopal Parish Day School

2018-2019 EMERGENCY AND MEDICAL FORM

Please submit completed form to any campus office by the first day of classes. In addition, if you have a new or rising kindergarten or seventh grade student, please submit an updated immunization record.

Student's Full Name: Date of Birth:

Preferred Name: Gender:

Parent/Guardian: Parent/Guardian:

Address: Address:

Cellular Number: Cellular Number:

Additional Number: Additional Number:

Email: Email:

Emergency contact if parent/guardian cannot be reached:

Name: Name:

Relationship to child: Relationship to child:

Cellular Number: Cellular Number:

Additional Number: Additional Number:

People permitted to pick up your child from school or school activities:

Name: Name:

Relationship to child: Relationship to child:

Cellular Number: Cellular Number:

Additional Number: Additional Number:

Name: Name:

Relationship to child: Relationship to child:

Cellular Number: Cellular Number:

Additional Number: Additional Number:

Will your child be attending the After School Program? Daily: Drop In:

Medical Information

Primary Care Physician: Telephone Number:

Preferred Hospital: Telephone Number:

Dentist: Telephone Number:

Health Insurance Company: Telephone Number:

Policy Number:

Group Number:

Are there any specific health problems that we should be aware of (allergies, chronic health issues, etc.)? If yes, please list.

Is this child taking any prescription / non-prescription medications and / or vitamins? If yes, please list.

Are there any restrictions on medical treatment for this child for either medical reasons (allergies, medication sensitivities, etc.) or religious reasons? If yes, please list.

Has your child ever had heart problems and / or seizures? If yes, please explain.

Has your child been hospitalized or had surgery in the last year? If yes, please explain.

As the parent(s)/guardian(s) of the student named above, we/I request the Head of School's designee to administer the medication(s) described below to my child at St. John's Episcopal Parish Day School. Please be advised, an Epipen is considered medication.

Medication	Amount/Strength/Dosage	Time(s) to be given	Purpose of Medication

Date Medication Begins: Date Medication Ends:

Prescribing Physician: Physician's Phone Number:

We/I understand that School personnel cannot be held liable for reactions or side effects from the administration of medication(s). We/I also grant permission for School personnel to contact the physician if there are questions or concerns about the medication(s).

Parent/Guardian Signature Date Telephone Number

Parent/Guardian Signature Date Telephone Number

Authorization for Emergency Medical Treatment

If my child, _____, should become ill or injured while at or under the supervision of St. John's Episcopal Parish Day School, I understand that the School will contact me immediately, or contact the person(s) I have designated if I cannot be reached.

Should the School be unable to reach me and / or the person(s) designated, the School is authorized to contact my child's physician and / or arrange for immediate medical treatment, and is also authorized to transport my child in an emergency vehicle to an emergency medical facility.

The physician and / or medical facility are authorized to administer emergency medical treatment necessary to ensure the health and safety of my child. I accept responsibility for payment and medical services rendered.

Parent/Guardian Signature Date Telephone Number

Parent/Guardian Signature Date Telephone Number