

New Covenant Christian School Student Emergency Procedure Form 2021-2022

**** Please list phone numbers clearly and accurately****

Student's Name _____ Grade _____ Birthdate _____ () Male () Female

Home Address _____ Home Phone # _____

Primary Contact Name _____ Cell # _____ Home # _____ Work # _____

Relationship _____ Address _____ Employer _____

Secondary Contact Name _____ Cell # _____ Home # _____ Work # _____

Relationship _____ Address _____ Employer _____

Child lives with _____ Best Phone # _____

Parent/Guardian email address _____

Alternative person to care for, transport, or authorize treatment for student if parent/guardian cannot be reached:

Name _____ Relationship _____ Phone# _____

Name _____ Relationship _____ Phone # _____

Student's Physician _____ Phone _____ Dentist _____ Phone _____

Is there anyone with whom your child should not have contact? () Yes () No *Who: _____

If emergency treatment is required, school personnel is authorized to use their own judgment in sending the child to the hospital or doctor most easily accessible. However, my hospital preference is _____

List dates and names of immunizations since last school year: _____

Names of other students living in same household: _____, Gr _____; _____, Gr _____; _____, Gr _____; _____, Gr _____; _____, Gr _____

CHECK AND EXPLAIN ANY AREA THAT APPLIES TO YOUR CHILD:

1. () Asthma 2. () ADD () ADHD 3. () Depression 4. () Diabetes 5. () Heart Problems () Murmur
6. () Seizure Disorder 7. () Bleeding Disorder 8. () Special Diet 9. () Hearing Problems () Ear Infections/tubes
10. () Operations () Serious Accident 11. () Glasses/Contacts 12. () Other _____
13. () Allergy to: _____ Reaction: _____

Explanation for 1-13 (Please include actions to be taken for allergic reaction, asthma attack, etc): _____

I authorize school personnel/volunteers to administer the following over-the-counter medicines and treatments, as deemed necessary and in the age-appropriate dosage, and I release personnel from any and all liability for damages as a result. Please check only the medications your child MAY BE GIVEN at school below:

- () Tylenol (Acetaminophen) () Advil/Motrin (Ibuprofen) () Antacids (Hyland4Kids ages 5-12/Tums ages 12+)
() Benadryl (Given for allergic reaction only) () Cough lozenges () Tears lubricant eye drops
() Triple antibiotic ointment () Hydrocortisone cream (1%) () Caladryl/Calamine lotion

***Parent/Guardian must complete the separate school consent forms for ALL other medications to be given at school.**

If student is taking any prescription medication(s), please list (Attach separate sheet, if needed)

Name of medication(s) _____ Dosage _____

Time taken _____ Taken for _____ Prescribing Doctor _____

() You MAY share the health information on this card with staff/faculty

() Please do NOT share this health information with staff/faculty

I authorize school personnel to share information (including immunizations, physicals, school notes, health information) regarding my child with his/her doctor and dentist. () YES () NO