New Covenant Christian School Student Emergency Procedure Form 2025-2026

** ***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 (Children's Equate Antacid under 12/Tums 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

_____ _____

******* NAME of PARENT/GUARDIAN ***** (Required)** ***** DATE *****