# Providence Christian School

## Student Emergency Information (2017-2018) *Part I*

Name ______________________________________________ Grade __________
Last First Middle

Home Phone ______________________ Cell Phone ______________________

Home Address ______________________________________________
Street City State Zip

Mailing Address ______________________________________________
Street City State Zip

Date of Birth ______________________ Place of Birth ______________________

Father ______________________________________________
Name Address Home phone

______________________________________________
Employer's Name Address Business phone

______________________________________________
Email address Cell phone

Step-Father ______________________________________________
(if applicable) Name Address Cell Phone

Mother ______________________________________________
Name Address Home phone

______________________________________________
Employer's Name Address Business phone

______________________________________________
Email address Cell phone

Step-Mother ______________________________________________
(if applicable) Name Address Cell Phone

Siblings ______________________________________________

***In the event of emergency, illness, or accident to our child in our absence, I (we) authorize the school to proceed as follows:***

Contact family physician ______________________ ______________________
Name Phone

**In the event of illness or emergency, persons to call when parents are not available:**

______________________________________________
Name Relationship Phone

______________________________________________
Name Relationship Phone

______________________________________________
Name Relationship Phone

# Student Emergency Information *Part II*

**Persons approved as carpool drivers for** ______________________________________________
Student's Name

______________________________________________________________________________
Name Phone Name Phone

______________________________________________________________________________
Name Phone Name Phone

______________________________________________________________________________
Name Phone Name Phone

______________________________________________________________________________
Name Phone Name Phone

***Please complete the following pertinent medical details regarding your child:***

Is your child subject to any of the following conditions which may result in a classroom emergency?

☐Epilepsy ☐Diabetes ☐Asthma ☐Allergies *Type of Allergies* ______________________________

Does your child need an inhaler while at school? ☐Yes ☐No

Does your child need an epi-pen to be kept at school? ☐Yes ☐No

*If you answered "yes" to any of the questions above, please explain below. Also, please note that additional paperwork may be required. You must provide any medications your child might need at school to the school office **before** the first day of school. Inhalers for students who are able to use them without help, may be kept with the student in the classroom. Please contact the school secretary with any questions.*

**Medications** - *Please list medications taken regularly*

| Medication | Dosage | Time of day taken |
|---|---|---|
| | | |
| | | |

**Hand Sanitizer Permission**

My child ____________________ has permission to use school-provided hand sanitizer. ☐Yes ☐No

**Health Insurance Company** ______________________________ **Policy Number** ______________

*I (We), the undersigned parent(s) of ______________________ (a minor) do hereby authorize Providence Christian School, as agent for the undersigned in our absence, to consent to x-ray examinations, anesthetic, medical or surgical diagnosis or treatment, and/or hospital care, which is deemed advisable by, and to be rendered under, the general and special supervision and upon the advice of any physician or surgeon licensed under the Medical Act, whether such diagnosis or treatment is rendered at the office of said physician or at any licensed medical facility. It is understood this authorization is given in advance of any specific diagnosis, treatment, or hospital care required, but is given to provide authority and power on the part of the aforesaid agent to give specific consent in any medical emergency to any and all such diagnoses, treatment, or hospital care which the aforementioned physician in the exercise of best judgment may deem advisable.* **This authorization shall remain in effect until revoked in writing and such revocation is delivered to said agent.**

***Parents or Guardians***

Father ________________________________________ Date ________________
Signature

Mother ________________________________________ Date ________________
Signature

**<u>A photocopy of this form is as valid as the original</u>**