GASTON CHRISTIAN SCHOOL

Medical Information/Emergency Release Form

Student's legal name _____ **Prefers to be called**_____

Home phone:_____ Date of birth ____/____/____ **Grade** _____ **Gender** (please circle): M F

Address_____ City_____ State_____ Zip Code_____

Parent information:

	Name	**Legal Guardian**	**Cell**	**Work**
Mother		Y/N		
Father		Y/N		
Step-parent		Y/N		

	Name	Phone
Pediatrician/primary care provider		
Dentist		

Insurance Company:_____

Policy number_____Phone_____

Emergency contact who will assume responsibility if parent cannot be reached:

Name: _____ home_____ cell_____

Name: _____ home_____ cell_____

Date of last tetanus shot: _____

(In case of accident or serious illness, the school will contact the parent/guardian. If the school is unable to contact the parent/guardian or person designated above, the school will make necessary arrangements for immediate treatment. Payment of any fees will be assumed by the parent/guardian.)

I hereby give my consent to any hospital and/or licensed physician or authorized provider to administer necessary emergency treatment to my child in the event such treatment is imperative and I cannot be contacted.

Parent/guardian signature: _____ Date _____

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Name _____

Medical History

Please indicate below (X) if your student has any of the following, and describe any treatments/medications, or special considerations:

	Asthma (worsened by exercise? Y N) (*Inhaler? Y N)
	Allergies (list all)_____(*EpiPen? Y N)
	Cardiac Issues
	Diabetes
	Gastrointestinal Issues
	Hearing Issues
	Kidney/Bladder Issues
	Migraines
	Orthopedic Issues
	Seizures
	Vision Issues (glasses/contacts/other _____)
	Other (list:_____)

***If your child requires having an inhaler and/or EpiPen at school, please have your physician complete the authorization form/treatment plan; these can be found on the website or obtained from the school nurse.**

Surgical history: Type(s)_____Year(s)_____

Disabilities or restrictions: _____

Monitoring devices or medical equipment to be used while at school? _____

Medications your student takes regularly: _____

Any other information about your child that would be helpful for the school nurse to know:

_____

No medications (over the counter or prescription) will be administered by the school nurse, other school personnel, or self administered by the student without the written authorization of a parent and physician/authorized provider. All prescription medications must be brought to school in the original container with the student's name and prescription information on the label.

All over-the-counter medication dosages will be administered according to the manufacturer's recommendations on the label unless otherwise indicated by a physician. Generic substitutions may be used for non-prescription medications listed. These forms will also be the authorized form used for off campus activities, including overnight trips. ****Medication Authorization forms can be found on the website or obtained from the school nurse****

Parent/guardian signature_____Date_____