

**OROVILLE CHRISTIAN SCHOOL**  
 Medical Information and Emergency Release Form  
**Please print all information.**

Student's Name: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Grade: \_\_\_\_\_

Physical Location Address: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

(include city, state, and zip)

(include city, state, and zip)

Father's (or legal guardian's) Name: \_\_\_\_\_

Mother's (or legal guardian's) Name: \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

(include city, state, and zip)

(include city, state, and zip)

Home Phone (if different than child): \_\_\_\_\_

Home Phone (if different than child): \_\_\_\_\_

Work Place: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Work Place: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Pager #: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Pager #: \_\_\_\_\_

**Emergency Pick up Release:** (other than Parent/Guardian)

Name: \_\_\_\_\_ Home #: \_\_\_\_\_ Work #: \_\_\_\_\_

Relationship to child: \_\_\_\_\_ Allowed to pick child up? (circle one) YES NO

Name: \_\_\_\_\_ Home #: \_\_\_\_\_ Work #: \_\_\_\_\_

Relationship to child: \_\_\_\_\_ Allowed to pick child up? (circle one) YES NO

Name: \_\_\_\_\_ Home #: \_\_\_\_\_ Work #: \_\_\_\_\_

Relationship to child: \_\_\_\_\_ Allowed to pick child up? (circle one) YES NO

<b>Medication Taken</b>		
<i>For office use ONLY!</i>		
Date	Dosage	Time

I give you permission to give my child: **TYLENOL:** YES \_\_\_\_\_ NO \_\_\_\_\_ / **ADVIL:** YES \_\_\_\_\_ NO \_\_\_\_\_

Oroville Christian School has permission for my child to go on field trips and other school activities that require travel. In the event of an accident or other emergency, I hereby authorize a representative of the school to make such arrangements as deemed necessary for my child to receive medical or hospital care, including necessary transportation. In the event our physician is not available at the time, I authorize care and treatment to be performed by any licensed physician or surgeon. The undersigned hereby agrees to bear all costs incurred as a result of the above.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Child's Physician: \_\_\_\_\_

Phone: \_\_\_\_\_

Policy/Group No.: \_\_\_\_\_

Physician's Address: \_\_\_\_\_

Insurance Company Name: \_\_\_\_\_

\_\_\_\_\_  
(include city, state, and zip)

**Medical Information:**

Health Problems: (check one) Asthma\_\_\_ Bee Sting Allergy\_\_\_ Diabetes\_\_\_ Epilepsy\_\_\_ Heart Condition\_\_\_ ADD/HD\_\_\_

Other: \_\_\_\_\_ Allergies (Specific): \_\_\_\_\_

Known Eye Condition: (check one) YES\_\_\_ NO\_\_\_ If yes, explain: \_\_\_\_\_

Known Hearing Problem: (check one) YES\_\_\_ NO\_\_\_ If yes, explain: \_\_\_\_\_

Physical Condition which limits: (check one) NONE\_\_\_ Classroom Activities\_\_\_ Physical Education\_\_\_

If there is a condition, please explain: \_\_\_\_\_

Dietary Restrictions: (check one) YES\_\_\_ NO\_\_\_ If yes, explain: \_\_\_\_\_

The education code (12020) REQUIRES parents to inform the school of the medications being taken by a student upon a physician's prescription.

Medications: \_\_\_\_\_ Current Dosage: \_\_\_\_\_

Prescribed by Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

**ALL MEDICATIONS, INHALERS, ETC MUST BE KEPT IN THE SCHOOL OFFICE.**

If you do not choose to sign the statement at the top of this form, please state action desired in the event of an accident / emergency:

\_\_\_\_\_ Parent/Guardian Signature: \_\_\_\_\_