

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

Medication Taken For office use ONLY!		
Date	Dosage	Time

I give you permission to give my child: **TYLENOL: YES ___ NO ___ ADVIL: YES ___ NO ___ COUGH DROP: 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: _____