

# CHRIST CHURCH SCHOOL STUDENT EMERGENCY CONTACT INFORMATION

Student Name \_\_\_\_\_  
Last First Middle

Date of Birth \_\_\_\_\_

HOME  
Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_

MOTHER  
Name \_\_\_\_\_ Cell Phone \_\_\_\_\_

Place of Employment \_\_\_\_\_ Work Phone \_\_\_\_\_

FATHER  
Name \_\_\_\_\_ Cell Phone \_\_\_\_\_

Place of Employment \_\_\_\_\_ Work Phone \_\_\_\_\_

IF we are unable to contact a parent, name a relative or friend who may be called upon or is authorized to pick up your child if the child is ill or if you are unable to pick up your child when contacted.

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

IF we are unable to contact the individuals listed above, what action do you wish Christ Church School to take if your child becomes ill or injured:

Every effort to respect the above stated recommendations will be made. I understand that final decisions on emergency care will rest with school authorities. Any time the above information changes, I will notify the school in writing.

Signed \_\_\_\_\_ Date \_\_\_\_\_

# CHRIST CHURCH SCHOOL AUTHORIZATION FOR EMERGENCY MEDICAL CARE

In the event that I cannot be reached to make arrangements for emergency medical attention at the time of an illness or injury, I hereby authorize a staff member of Christ Church School to take my

child, \_\_\_\_\_,

to \_\_\_\_\_ (hospital/clinic)

to be seen by \_\_\_\_\_ (Doctor's Name)

Telephone number if hospital or clinic \_\_\_\_\_

Please list any allergies or other information the school should know about your child's medical history in case of an emergency OR indicate "not applicable":

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Signed \_\_\_\_\_ Date \_\_\_\_\_

# CHRIST CHURCH SCHOOL STUDENT HEALTH FORM

Student Name \_\_\_\_\_  
Last First Middle

Date of Birth \_\_\_\_\_

## DOCTOR'S STATEMENT

I have examined the above named child within the past year and find that he/she is physically able to take part in the programs at Christ Church School.

Physicians Signature \_\_\_\_\_ Date \_\_\_\_\_

Place of Employment \_\_\_\_\_ Work Phone \_\_\_\_\_

## PARENT'S STATEMENT If you do not have the above

My child has been examined within the past year by a licensed physician and is able to participate in the programs at Christ Church School.

Physicians Name \_\_\_\_\_

Phone Number \_\_\_\_\_

**Within the next 12 months**, I will obtain a physician's statement or similar form from a health service or clinic and will submit it to Christ Church School.

**OR**, my child has an appointment for a physical examination. I will submit the physician's statement or health service/clinic form to Christ Church School following the examination.

Appointment Date \_\_\_\_\_

Signed \_\_\_\_\_ Date \_\_\_\_\_

## NOTE

If medical diagnosis and treatment and/or immunization and TB testing conflict with your religious beliefs, you must sign an affidavit and attach it to this form.

If immunizations and/or TB testing would be injurious to your child or family, you must obtain a certificate signed by a physician and attach it to this form.