

Calvary Episcopal School & College Preparatory

Student Emergency Medical Form

School Year: _____

To be renewed each school year

(Separate form to be filled out for each child attending Calvary)

_____	_____	_____
Student's Last Name, First Name	Middle	Nickname
_____	_____	_____
Student's Home Address	City	State
_____	_____	_____
Student's Date of Birth	Student's Grade Level	Parent's Primary Email Contact

In case of Emergency, illness or accident to the above named student, the school is authorized to proceed as indicated below in order of preference for emergency contact. Number below contacts with a 1, 2, 3, etc. to indicate preference order for being contacted.

()	Father's Name: _____ Home Phone: _____	Office Phone: _____ Cell Phone: _____
()	Mother's Name: _____ Home Phone: _____	Office Phone: _____ Cell Phone: _____
()	Other Name and Relationship: _____ Home Phone: _____	Office Phone: _____ Cell Phone: _____
()	Other Name and Relationship: _____ Home Phone: _____	Office Phone: _____ Cell Phone: _____

_____	_____
Father's Employer	Employer Business Address
_____	_____
Mother's Employer	Employer Business Address

Parents' Marital Status: _____

_____	_____	_____	_____	_____
Step Parent's Name (if applicable)	Step Parent's Address	City	State	Telephone Number
_____	_____	_____	_____	_____
Step Parent's Name (if applicable)	Step Parent's Address	City	State	Telephone Number

_____	_____
Student's Physician	Physician's Office Number
_____	_____
Student's Dentist	Dentist's Office Number

In the event reasonable attempts to contact parent/guardians have been unsuccessful, I hereby give my consent to authorize the provision of emergency treatment, and the transfer of the child to any hospital reasonably accessible.

This authorization does not refer to major surgery unless the medical opinions of two licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such.

The undersigned, do hereby authorize officials of Calvary Episcopal School & College Preparatory to contact directly the persons named on this page to render such treatment as may be deemed necessary in an emergency for the health of said child. In the event that the named persons or physician cannot be contacted, the school officials are hereby authorized to take whatever action is deemed necessary, in their judgment, for the health of the aforesaid child. I will not hold CES/CECP financially responsible for the emergency care and/or transportation for the said child.

I will promptly alert the school of any changes in the emergency information contained on this form.

_____ Parent Signature _____ Date

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Please place a check mark (v) in the box next to any/all conditions that your child may have. Medication, Physical conditions, and Medical Diagnoses can change year to year, please fill in all information completely for this CURRENT SCHOOL YEAR.

Confidential Medical Information (Please be thorough with information each school year)

- ADD or ADHD (Please circle) Medication: _____ (Please circle) Once or Twice daily
Asthma/Respiratory Problems: Medication: _____
Auto-Immune Disorder (Please Explain): _____ Medication: _____
Blood Disorder (Please Explain): _____ Medication: _____
Diabetes (will need a Diabetes Medical Management Plan for School) Medication: _____
Diagnosed Bone or Muscle Condition (Please Explain) _____ Medication: _____
Eating Disorder (Please Explain): _____
Frequent Nosebleeds or Ear Infections: _____
Heart Condition (Please Explain): _____ Medication: _____
Seasonal Allergies to: _____ Medication: _____
Medication Allergies (Please list Prescription and over the counter): _____
Food Allergies (will need a Food Allergy Action Plan for school): _____
History of Life Threatening/Severe Allergic Reaction (Please explain): _____
Migraine Headaches or Frequent Headaches (Please circle) Medication: _____
Physical Impairment (Please explain): _____ Assistance Needed: _____
Seizures (Please specify type): _____ Medication: _____
Diagnosed Stomach Conditions (Please explain): _____ Medication: _____
Urinary, Kidney, Bowel Conditions (Please explain): _____ Medication: _____

Immunization Records

New Students – Acceptable Evidence of Vaccination:

Documentation of vaccines administered that include the signature or stamp of the physician or his/her designee, or public health personnel is acceptable; an official immunization record generated from a state or local health authority, such as a registry; or a record received from school officials including a record from another state is acceptable.

Returning Students – Updated Immunization records must be a copy of the physician’s record which states the date the dose was administered.

Medications That Will Be Kept In School Clinic for the Use of Calvary Students

We/I give permission to administer to my child the following over-the-counter medications: (Please check in the space provided):

- Tums Benadryl Gel Oragel Carmex Neosporin
Tylenol/Acetaminophen Motrin/Ibuprofen/Advil Bactine/Antiseptic Hydrocortisone Cream

I understand these are the only over the counter medications in which CES/CECP provides for my child. A supply of these medications will be kept in the Nurse’s Office to be administered by the School Nurse per her discretion. (Parents of students that are in Pre-K through 5th will be called prior to giving the student Tylenol/Acetaminophen/Motrin/Ibuprofen/Advil). No Cough Drops to be given out to students due to choking hazard.