

EMERGENCY INFO FORM

CITY CHRISTIAN SCHOOLS 2011-12

PLEASE **PRESS HARD** AND COMPLETE ALL BLANKS IN BLUE OR BLACK INK. IF NONE, INDICATE "NONE."

Student's Name _____ Birthdate _____
(Last) (First) (Middle)

Grade _____ Social Security # _____ - _____ - _____ Gender _____

Address _____
(Street) (City) (State) (Zip)

Parent's Name _____

Home Phone # (_____) _____

Father's Work # (_____) _____ Mother's Work # (_____) _____

Father's cell ph. # (_____) _____ Mother's cell ph.# (_____) _____

Family Physician _____ Phone # (_____) _____

Name of Medical Insurance Co. _____ Group or I.D. # _____

Local Family/Friend who should be contacted in an emergency situation when parents cannot be reached:

Name _____ Phone # (_____) _____

Relationship _____

Diphtheria/Tetanus (DTaP, DT, Td, Tdap) Immunization Date _____

During the past year my child: If Yes, please comment

Has had injuries requiring medical care No Yes _____

Has had a surgical problem..... No Yes _____

Has had chronic illness or other problem No Yes _____

Do you know of any reason why your child
should not participate in any activity?..... No Yes _____

Medications taken on a regular basis No Yes _____

Are immunizations current?..... No Yes _____

Special health problems (i.e., diabetes, seizure disorder, asthma, allergies, etc.) _____

Please read and check appropriate boxes below regarding off-campus activities.

Elementary/Junior High/High School

Yes No Our child has permission to participate and travel with the coach, staff member, or designated volunteer in all supervised field trips and extracurricular activities. I understand that school authorities will use their best judgement in determining emergency care and procedures.

Junior High/High School

Yes No My junior high/high school child has permission to travel off campus with a CBC/CCS staff member (paid or volunteer) in the staff member's personal vehicle when involved in an occasional, short term, unscheduled activity the administration considers appropriate.

Parent/Guardian Signature _____ Date _____

Original – Medical Records

Copies for homeroom teachers and for coaches