



# Kingsway Christian School

## Emergency and Medical Information Release

**Please Be Advised**

- To insure the health and well-being of your child, this information may be shared with other school staff/faculty as deemed necessary.
- If emergency medications are needed at school, they **MUST** be provided at the school or student will not be allowed to participate in school field trips or other off-campus activities.

Student's Name (Please Print) \_\_\_\_\_ Grade \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Parent/Guardian Name \_\_\_\_\_

**Father/Guardian Phones**

Home \_\_\_\_\_ Business \_\_\_\_\_ Cell \_\_\_\_\_

**Mother/Guardian Phones**

Home \_\_\_\_\_ Business \_\_\_\_\_ Cell \_\_\_\_\_

**Two Local Emergency Contacts**

#1 \_\_\_\_\_ Phone \_\_\_\_\_ Relation to Student \_\_\_\_\_

#2 \_\_\_\_\_ Phone \_\_\_\_\_ Relation to Student \_\_\_\_\_

Physician Name \_\_\_\_\_ Phone \_\_\_\_\_ Hospital Preference \_\_\_\_\_

Medical Conditions/Health Concerns (including allergies) \_\_\_\_\_

Medications (please include Dosages and Routes) \_\_\_\_\_

Which Of These Would Be Taken At School? \_\_\_\_\_

Medications needed while at school **MUST** be brought by an adult to the nurse's or school office to be dispensed (*students are allowed to carry inhalers if a special permission note signed by the doctor is on file and the inhaler is labeled*). A prescription drug **MUST** have a current pharmacy label on the container and a medication permission form filled out from the parent or guardian giving permission to dispense the medicine. A non-prescription medication must be brought in its original container and medication permission form filled out by parent/guardian. **No medication will be dispensed without written permission. Medications must be transported by AN ADULT directly to the school or nurse's office and picked up by an adult to ensure the safety of our students.**

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_



# Kingsway Christian School

## Emergency Treatment Consent Release

In the event of our absence, I/we hereby allow a representative of Kingsway Christian School to authorize consent for medical treatment in the event of an emergency. I/we understand that if circumstances permit, and it is not detrimental to the health and well-being of my child, we and/or our physician will attempt to be contacted. In signing this consent, I/we are authorizing consent for medical treatment including, but not limited to, administration of anesthesia, surgical intervention, blood transfusions, and necessary medical procedures.

This consent/authorization shall include and extend to all matters which are required by Hospitals and Health Care Centers. In consideration of the services above which are rendered to the child names below, I/we agree to pay for all such services. This authorization shall remain in effect through May 31 of each year unless revoked in writing by me/us.

Student's Name *(Please Print)* \_\_\_\_\_ Grade \_\_\_\_\_

Father/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Mother/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

In the event that this form is executed by only one parent/guardian, please state the reason the other parent/guardian can not be obtained:

\_\_\_\_\_

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## OTC Medication Release

In an effort to better serve our families, we will be making over-the-counter medications available to our students. Only the medications listed below will be available and we will only dispense the amount recommended on the label and for the indications listed. **One parent/guardian must sign this form and initial** which medications you have given us permission to dispense. If no signature and initials are obtained, we will not dispense any medications.

\_\_\_\_\_ Acetaminophen 325mg tablet or 160mg/tsp. liquid (*Tylenol*)

\_\_\_\_\_ Throat lozenges with Menthol 5mg (*Halls, Robitussin drops*)

\_\_\_\_\_ Calcium carbonate 500mg - regular strength (*antacids, Tums*)

\_\_\_\_\_ Caladryl lotion - regular strength

Initial \_\_\_\_\_ Signature \_\_\_\_\_ Relationship to Student \_\_\_\_\_



# Kingsway Christian School

## Immunization Record

*Only needed for new student enrollment*

Date \_\_\_\_\_

Student's Name *(Please Print)* \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Address \_\_\_\_\_

Immunization dates should include month/date/year, e.g., 1/1/09.

The following immunizations *(or boosters)* are required before school enrollment:

**DTP Primary Series\*** #1 \_\_\_\_\_ #2 \_\_\_\_\_ #3 \_\_\_\_\_

*(Diphtheria, Tetanus, Pertussis)*

**DTP Boosters** #4 \_\_\_\_\_ #5 \_\_\_\_\_

or

**D/T Booster** #4 \_\_\_\_\_ #5 \_\_\_\_\_

**Primary Polio Series\*** #1 \_\_\_\_\_ #2 \_\_\_\_\_ #3 \_\_\_\_\_

**Polio Booster\*** #4 \_\_\_\_\_

**MMR #1\*** \_\_\_\_\_

*(Mumps, Measles, Rubella)*

**MMR #2\*** \_\_\_\_\_

**Varicella\*** \_\_\_\_\_

*(Chicken Pox Vaccine)*

**Note:** *Written parental history of chicken pox disease is acceptable with date of disease and signature.*

**Hepatitis B\*** *(Please specify 2 or 3 dose series)*

2 dose series #1 \_\_\_\_\_ #2 \_\_\_\_\_

3 dose series #1 \_\_\_\_\_ #2 \_\_\_\_\_ #3 \_\_\_\_\_

**Current Tetanus** \_\_\_\_\_

Physician's Name \_\_\_\_\_ M.D. Physician's Phone \_\_\_\_\_

It is a state requirement that a letter stating the reason for exemption of vaccinations be on file every new school year. Please provide this letter during enrollment if vaccinations are not given.

\* Indicates State Requirement