



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:

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