THE BEAR CREEK SCHOOL

Student and Emergency Information 2019-2020

Student Information

Full Name: _____ **Grade:** _____ Campus: _____

Date of Birth: _____ Cell Phone: _____

Preferred Name: _____ Email: _____

Gender: ☐ Male ☐ Female

Household Information

Name: _____ Phone: _____

Address: _____

Parent Information	Father	Mother	
Name:		**Name:**	
Home Address:		**Home Address:**	
Home Phone:		**Home Phone:**	
Email:		**Email:**	
Work Phone:		**Work Phone:**	
Cell Phone:		**Cell Phone:**	
Employer:		**Employer:**	

Medical Release for Treatment

If the parents/guardians and/or authorized licensed healthcare provider cannot be reached at the time of an emergency and if immediate or urgent observation or treatment is needed in the judgment of the school authorities, I/we authorize and direct the school authorities to send my/our child/ward to the hospital or licensed healthcare provider listed on our family profile, if accessible, and if not, to an appropriate alternative provider. Additionally, I/we hereby authorize, appoint, and empower The Bear Creek School to act as my/our agent to furnish on my/our behalf such oral or written authorization to provide medical or surgical services as may be required, and I/we release The Bear Creek School, from any liability which might arise from the giving by it of such authorization; it being my/our desire that my/our child/ward be furnished with such medical or surgical services as soon as reasonably possible after the need arises.

I/We agree and acknowledge that I/we are solely responsible for the expense of any medical or surgical service obtained by the School for my/our child/ward, including without limitation, ambulance, EMT, or other emergency response or transportation.

I/We hereby acknowledge that I/we read and understand English and have read and understand the terms and conditions set forth in this Medical Release for Treatment. Alternatively, I/we hereby acknowledge that if I/we do not read and understand English that I/we have consulted with someone who does and such person has fully explained the terms and conditions set forth in Medical Release for Treatment. I/We fully understand the terms and conditions set forth in this Medical Release for Treatment.

_____ _____ _____

Parent/Guardian Name **Signature** **Date Signed**

Emergency Contacts

Name	Home Address	Relation	Home	Mobile	Work

Version 09/22/2011 Revised 5/9/2019

Full Name: _____ **Date of Birth:** _____ **Grade:** _____ **Campus:** _____

Student Medical Information

Allergies and Symptoms

_____
_____
_____

General Medical Notes

_____
_____
_____

Current Medications *List all medications the student takes on a regular basis (prescribed, over-the-counter, or naturopathic) at home or during school hours. Include allergy, ADD/ADHD, migraine, and emergency medications such as epinephrine and inhalers.*

_____
_____
_____

If medication must be administered at school, a health care provider signed ***Waiver and Authorization to Administer Medication*** must be on file.

School-Provided Medications Release

Over-the-counter medications available from the School and specified on my/our child's/ward's Medical Profile (see below) may be administered to my/our child/ward, and I/we attest that my/our child/ward has no known allergies to these medications. I/We release and hold The Bear Creek School harmless from any liability that may arise from the administration of these medications at School. I/We acknowledge that these medications may not always be administered by an R.N., and may not always be available.

I/We hereby acknowledge that I/we read and understand English and have read and understand the terms and conditions set forth in this School-Provided Medications Release. Alternatively, I/we hereby acknowledge that if I/we do not read and understand English that I/we have consulted with someone who does and such person has fully explained the terms and conditions set forth in this School-Provided Medications Release. I/We fully understand the terms and conditions set forth in this School-Provided Medications Release.

_____ _____ _____
Parent/Guardian Name **Signature** **Date Signed**

May the School administer...		***For skin/topical complaints, may the School administer…***	
Acetaminophen (Tylenol)?	☐ Yes ☐ No	Antiseptic?	☐ Yes ☐ No
Antihistamine?	☐ Yes ☐ No	Triple antibiotic cream?	☐ Yes ☐ No
Cough drop/throat lozenge?	☐ Yes ☐ No	Anti-itch cream?	☐ Yes ☐ No
For digestive upset, may the School administer…		Hydrocortisone cream (1%)?	☐ Yes ☐ No
Tums?	☐ Yes ☐ No	Sting-off?	☐ Yes ☐ No

Health Care Provider and Insurance

Doctor's Name: _____
Health care facility, Physician's office, or Clinic name: _____
Facility/Office/Clinic Phone: _____

Insurance Company: _____ Group #: _____