



# 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	
<b>Name:</b>		<b>Name:</b>		<b>Name:</b>	
<b>Home Address:</b>		<b>Home Address:</b>		<b>Home Address:</b>	
<b>Home Phone:</b>		<b>Home Phone:</b>		<b>Home Phone:</b>	
<b>Email:</b>		<b>Email:</b>		<b>Email:</b>	
<b>Work Phone:</b>		<b>Work Phone:</b>		<b>Work Phone:</b>	
<b>Cell Phone:</b>		<b>Cell Phone:</b>		<b>Cell Phone:</b>	
<b>Employer:</b>		<b>Employer:</b>		<b>Employer:</b>	

## 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

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 \_\_\_\_\_

<i>May the School administer...</i>		<i>For skin/topical complaints, may the School administer...</i>	
Acetaminophen (Tylenol)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Antiseptic?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Antihistamine?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Triple antibiotic cream?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cough drop/throat lozenge?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Anti-itch cream?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>For digestive upset, may the School administer...</i>		Hydrocortisone cream (1%)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Tums?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sting-off?	<input type="checkbox"/> Yes <input type="checkbox"/> 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 #: \_\_\_\_\_