STUDENT HEALTH AND EMERGENCY INFORMATION

Atlantic Shores Christian Secondary Campus ~ 1217 North Centerville Turnpike ~ Chesapeake, VA 23320 ~ (757) 479-9598 ~ Fax: (757) 479-5311

Atlantic Shores Christian Elementary Campus ~ 1861 Kempsville Road~ Virginia Beach, VA 23464 ~ (757) 479-1125 ~ Fax: (757) 479-8742

Student Name: _____ DOB: ___/___/___ Grade: ____ School Year: _____

PARENT/ GUARDIAN EMERGENCY CONTACT INFORMATION

Mother's Name: _____ Cell # : _____ Work # : _____

Father's Name: _____ Cell # : _____ Work # : _____

Guardian/Emergency Contact: _____ Cell # : _____ Work # : _____

PHYSICIAN INFORMATION

Name:_____

Phone #: _____

Preferred Hospital: _____

DENTIST INFORMATION

Name:_____

Phone #: _____

HEALTH HISTORY—Please do not leave any blanks, fill in appropriate information or indicate N/A

Allergies: _____ Do these allergies require emergency measures? Explain: _____

_____

Injuries or conditions that require special consideration: _____

Appliances (braces, contacts, glasses, etc.): _____

Current Medications: ( ) Over-The-Counter: _____ ( ) Prescription: _____

Chronic illnesses (examples asthma, diabetes, other): _____

_____

PERMISSION TO TREAT ILLNESS/INJURY, ADMINISTER* MEDICATIONS, AND *EMAIL MEDICAL INFORMATION

I hereby acknowledge that I have read and understand the Parental Responsibilities for Medication Administration as stated in the Student Handbook. I release ASCS and its employees from any claims of liability connected with its reliance on this permission, and I agree to indemnify, defend and hold them harmless from any claim or liability connected with such reliance. I hereby authorize employees of ASCS to take such measures as deemed appropriate when my child is ill or injured. I understand that it may include the advanced first aid administration of an Epi-pen in the event of anaphylaxis (a life-threatening allergic reaction). In the event of a serious illness and/or injury, the rescue squad may be utilized and treatment and/or hospital care may be rendered under the advisement of appropriate medical personnel. In such event, I understand that employees of ASCS will make reasonable efforts to contact a parent/guardian, emergency contact, or physician as feasible under the circumstances. I hereby give permission for ASCS to administer the approved over-the-counter medications (Acetaminophen, Ibuprofen, cough drops) and/or any prescription medications I have provided with signed authorization. I give ASCS permission to send email notifications of all medical events/medication administration during school hours. I understand that if I do not wish to receive email notifications of medical events, I must notify the school in writing within seven days after enrollment or the first day of school, whichever comes first.

Parent/Guardian Signature _____ Date _____