

STUDENT HEALTH AND EMERGENCY INFORMATION

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

Atlantic Shores Christian Elementary School~ 1217 North Centerville Turnpike ~ Chesapeake, , VA 23320 ~ (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 any of the following 3 over the counter medications (Acetaminophen, Ibuprofen, cough drops). I understand that the school will not administer prescription or other over the counter medications until I provide a separate authorization form. I give ASCS permission to send email notifications of all medical events/medication administration during school hours. I understand that if I do not consent to this medical release in it's entirety, I must complete and sign a "Medical Release Non-Consent Form" with the school office within 30 days of signing the school contract.

Parent/Guardian Signature _____ Date _____