STUDENT HEALTH AND EMERGENCY INFORMATION

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

Atlantic Shores Christian Elementary School ~ 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 # _____

Emergency Contact _____ Cell # _____ Work # _____

PHYSICIAN INFORMATION

Name _____

Phone # _____

DENTIST INFORMATION

Name _____

Phone # _____

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

Allergies _____ _____

What reaction do they have to the allergen(s) ? _____

Chronic illnesses (ex. Asthma, Diabetes, Migraines, other) _____

_____

Medical Conditions that require special consideration _____

_____

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

Current Medications (Over-The-Counter) _____

Current Medications: (Prescription) _____

MEDICAL RELEASE TO TREAT ILLNESS/INJURY, ADMINISTER* MEDICATIONS, AND *EMAIL NOTIFICATIONS

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 a reasonable effort 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 <u>will not</u> 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 _____