

Coastline Christian Academy

Emergency Information and Medical Release Form

Student's Name: _____ Date of Birth: _____

Sex: (M/F) _____ Age: _____ Weight: _____ Height: _____

Name of Father/Guardian _____ Work Phone: _____
 Cell Phone: _____ Home Phone: _____

Name of Mother/Guardian _____ Work Phone: _____
 Cell Phone: _____ Home Phone: _____

Place an "X" in the box by the PARENT to be called FIRST in an emergency.

Name of Physician: _____ Office Phone: _____

Are there any specific medical conditions, recent hospitalizations or allergies we should know about?

May your child take...

Tylenol (Acetaminophen)	Advil (Ibuprofen)	Tums/Roloids	Cough Drops
<input type="checkbox"/> yes, child dosage	<input type="checkbox"/> yes, child dosage	<input type="checkbox"/> yes	<input type="checkbox"/> yes
<input type="checkbox"/> yes, adult dosage	<input type="checkbox"/> yes, adult dosage	<input type="checkbox"/> no	<input type="checkbox"/> no
<input type="checkbox"/> no	<input type="checkbox"/> no		

(As per recommendations on the package unless specific amount listed below)

Would you like us to call you before we administer any of these medications?

Call	Call	Call	Call
<input type="checkbox"/> yes	<input type="checkbox"/> yes	<input type="checkbox"/> yes	<input type="checkbox"/> yes
<input type="checkbox"/> no	<input type="checkbox"/> no	<input type="checkbox"/> no	<input type="checkbox"/> no

Check here if you want us to give medication if we have called and can't reach you _____

NOTE: If your child must receive medication other than those listed on the previous page at any time during the school year, please complete a Request for Administration of Prescription Medication During School Hours form in the Administration Office. We will NOT be able to administer medication without your specific instructions.

Please list two neighbors, relatives or friends who will be able to assume care of your child if you cannot be reached. By your signature on this form, you grant Coastline Christian Academy permission to release the above-named student to one of the individuals listed below.

Name _____ Relationship _____

Address _____ Phone _____

Name _____ Relationship _____

Address _____ Phone _____

INSURANCE INFORMATION

Is this student covered by medical or health insurance? (Circle One) YES / NO
If **YES**, please complete the following:

Name of Insurance Co. _____

Name of Insured _____ Type of Coverage _____

Group/Account No _____ Certificate No. _____

If pre-authorization is required prior to treatment, please provide the phone number and contact person:

Contact Person: _____ Phone No _____

Coastline Christian Academy will not be responsible for bills resulting from errors in reporting insurance or pre-authorizations.

We, the undersigned parents/guardians of _____, do hereby authorize representatives of Coastline Christian Academy to take our child to a medical facility in the event our child should require medical care. We further authorize any licensed physician to render any medical care deemed necessary in an emergency. We understand that every effort will be made to reach us within a reasonable amount of time prior to medical treatment.

Signature of Father/Guardian

Date

Signature of Mother/Guardian

Date