HERITAGE CHRISTIAN ACADEMY

Student Last Name | First Name | Middle | Grade

EMERGENCY INFORMATION: Please fill out this form completely and accurately as this information will be used to contact you if your child is in need of medical attention due to illness or injury. **Please print clearly.**

Parent/Guardian Name

Email

Cell Phone Number

Work Phone Number

Work Address

Parent/Guardian Name

Email

Cell Phone Number

Work Phone Number

Work Address

In the event, you are unavailable, please provide us a name of another person authorized to pick your child up from school.

Name | Phone Number | Relationship to Student

Address

In case of accident or serious illness. I request that the school contact us, as parents. If the school is unable to reach us, I hereby authorize the school to call the physician listed below and to follow his/her instructions. If the physician cannot be reached, the school may make whatever arrangements are necessary.

Physician's Name | Street Address

Office Phone Number | City | State | Zip

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Does your child have asthma? _____ If yes, what triggers an asthma attack in your child?

Please be specific: _____

Does your child take asthma medication? _____ If yes, please complete the following:

When Symptomatic:		Regularly:		Before Exercise:	
Medication	_____	Medication	_____	Medication	_____
Dosage	_____	Dosage	_____	Dosage	_____
Frequency	_____	Frequency	_____	Frequency	_____

Does your child have an **Emergency Inhaler**? _____

If yes, does your child know WHEN and HOW to use it? _____

How often does your child need to use his **Emergency Inhaler**? _____

***If your child's asthma is aggravated on a school day, please call or send a note to inform their teacher of your child's medications and specific activity level for the day.*

What, if any, seasonal or environmental allergies does your child have? _____

Please list any specific changes to your child's vision or hearing that have occurred in the past year?

Vision: _____ Hearing: _____

Does your child need special classroom seating due to vision or hearing problems? _____

	Yes or No	Please list all medications or allergies
Medication Allergies		
Food Allergies		
Take Medication Regularly		
Diabetic		

Date of your child's last Tetanus immunization: _____

Other Medical Conditions: (List any pertinent medical information that a physician should know **before** treating your child in an emergency situation i.e. allergies, injuries, surgeries, etc.)

_____

_____

In case of an emergency, I give permission for _____ to be treated medically or surgically by an attending physician.

I understand that medications may not be administered by HCA staff unless prescribed by a doctor.

_____	_____
Parent/Guardian Signature	Parent/Guardian Signature
_____	_____
Date	Date