Lake Norman Christian School

2009-2010 Emergency Contacts – Medical Information – Field Trip Release Form

Student's Name ____Grade/Teacher Name ______________
Address ____ Phone ___________________________
E-Mail Addresses ____
Date of Birth ____ Social Security #__________________

Father's Name ____ Cell # __________________________
Place of Business _______________________________________Work Phone ______________________
Mother's Name ____ Cell # __________________________
Place of Business _______________________________________Work Phone ______________________

Persons authorized to pick child up from school/emergency contacts if parents are unavailable:

1. ____ Phone ________________
2. ____ Phone ________________
3. ____ Phone ________________

Persons ***not*** authorized to pick up child:
1. ____ 2. ____

Health/Emergency Treatment Information

Child's Physician ____________________________________ Phone ____________________________
Child's Dentist ______________________________________ Phone ____________________________
Hospital of Choice ____
Insurance Company ___________________________________ Policy # ___________________________
Allergies: Please circle one: YES or NO Date of last Tetanus shot ______________________________
List specific allergies if YES ____
***Note, we require a doctor's notice if allergic to certain foods/meds. Please attach to back of this form.**
Does your child carry an epi-pen for allergies? YES or NO
What happens to your child when they have an allergic reaction? (swelling, itching, shortness of breath, etc.) ____
Please list any health conditions your child has (i.e. diabetes, seizures, migraines, etc.) _______________
____
Medications: Please list any medications that your child takes at home on a daily basis. (i.e. Ritalin, Adderall, asthma inhalers, or over the counter meds) ____
____

***Your child will not receive any medications at school unless we have a signed "Authorization for Prescription Medication" form from your healthcare provider stating the purpose of the medication. The parents will also be responsible for purchasing their own medications for their children. All medications have to be kept in the school office. The office will have Benadryl in the health room for EMERGENCY situations only (allergic reactions to bee-stings, ant bites, peanut butter allergies, etc.) I release LKNC faculty/staff from any liability should my child have any adverse reaction to this medication.**
Parent Signature: ____

Authorization for Emergency Medical Treatment/Field Trip Participation

1. Permission is granted for faculty/staff of LKNC to render first aid and to obtain the services of a licensed physician, and arrange for transportation to the closest hospital in case of the need for immediate medical attention.
2. Permission is also granted to the attending physician to render whatever treatment is medically necessary for the well being of my child. The expenses incurred will be the responsibility of the person whose signature appears below.
3. I hereby release LKNC faculty/staff including volunteer chaperones from any and all liability in case of an accident or any other injury which might occur to my child through administering first aid or transportation to a medical facility, and I hereby release said aforementioned persons from any liability because of any injury or damage which might occur.
4. My child has permission to attend field trips approved by LKNC. This release will be effective until the end of the school year or upon withdrawal from LKNC. I hereby release LKNC faculty/staff and any driver of automobiles or buses from liability which might result.
5. I understand that every effort will be made to notify me or an emergency contact person stated above before such action is taken.

Signature of Parent or Legal Guardian ____
Date ____