Lakeview Christian School

EMERGENCY MEDICAL RELEASE FORM

Please complete (**front and back**) the following important information for our files. This form will be carried on all field trips.

Student Name_____Grade:_____Age:_____

Address _____

Family Physician's Name _____

Address _____ Phone _____

First Emergency Contact (Parent Information):_____

Home Phone _____ Mom's Cell _____ Dad's Cell _____ Work _____

Email address: _____

Second Emergency Contact (Other Than Parent):_____

Relationship to Student _____

Home Phone _____ Cell _____ Work _____ Pager _____

My child is allergic to the following substances:

_____

_____

My child has the following limitation or health consideration (include chronic health conditions /medical history):

Vision _____ Hearing _____ ADD/ADHD _____

Allergies_____ Other_____

Does your child take prescription medication regularly? Yes or No

If you answered yes, please list medication, frequency, and the condition requiring it.

_____

_____

(Continue on Back)

FIRST AID AND EMERGENCY MEDICAL CARE CONSENT FORM

I understand that my child will be participating in a number of activities for the school year of 2018-2019 which carry with them a certain degree of risk including the playground and field trips. I consent for my child to participate in school activities.

I understand and give consent for my child to travel to and from these events in transportation provided by volunteer drivers.

I authorize the staff to give basic first aid when appropriate.

It is my understanding that Lakeview Christian School will attempt to notify me in case of a medical emergency involving my child. However, if I cannot be reached, I hereby authorize the school to transport my child to the nearest medical care facility and to hire a doctor or health-care professional, and I give my permission to the doctor or other health-care professional, to provide the medical services he or she may deem necessary for the safety and protection of my child. I will pay for any medical expenses so incurred.

Medical Insurance Information (if available):

Name and Social Security Number of Policy Holder: _____

Insurance Company: _____Policy/Group#_____

Print Parent Name: _____

Signature of Parent or Guardian: _____

Sworn to and subscribed before me this

_____
ID Type Number

_____ day of _____, 201____.

_____
Notary Public, State of Florida

My commission Expires _____