

**Shannon Forest Christian School**  
Student Emergency Sheet for 2011-2012

Date: \_\_\_\_\_

Student's name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Grade: \_\_\_\_\_

*To the Parent or Guardian: For the health and safety of your son/daughter, both sides of this form must be completed and returned to SFCS. To serve your child in case of ACCIDENT OR SERIOUS ILLNESS, it is necessary that you furnish the following information for emergency calls.*

Mother/Guardian: \_\_\_\_\_ Home #: \_\_\_\_\_ Work #: \_\_\_\_\_ Cell #: \_\_\_\_\_

Father/Guardian: \_\_\_\_\_ Home #: \_\_\_\_\_ Work #: \_\_\_\_\_ Cell #: \_\_\_\_\_

**List two that will be called ONLY in case of an emergency if you cannot be reached:**

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Ph# Home: \_\_\_\_\_ Cell: \_\_\_\_\_

Ph# Home: \_\_\_\_\_ Cell: \_\_\_\_\_

*Please indicate any health conditions that require treatments, procedures, medications, or health monitoring for your child during the school day. Please list the physician treating your child as well as the office phone number.*

\_\_\_\_\_  
\_\_\_\_\_

List all allergies: \_\_\_\_\_

Is your child allergic to latex? \_\_\_\_\_ yes \_\_\_\_\_ no

***Please note: No medication will be given without permission regarding amount and frequency.***

The following over the counter medications are available during school hours:

(Please indicate all information for the medications your student has permission to receive from a school staff member.)

|   |                 |              |
|---|-----------------|--------------|
| _____ Advil tablets (200 mg/tab): dosage _____        | frequency _____ | reason _____ |
| _____ Advil liquid (100mg/ml): dosage _____           | frequency _____ | reason _____ |
| _____ Benadryl tablets (25 mg/tab): dosage _____      | frequency _____ | reason _____ |
| _____ Benadryl liquid (12.5 mg/5ml): dosage _____     | frequency _____ | reason _____ |
| _____ Cough Drops: dosage _____                       | frequency _____ | reason _____ |
| _____ Hydrocortisone Cream: dosage _____              | frequency _____ | reason _____ |
| _____ Neosporin: dosage _____                         | frequency _____ | reason _____ |
| _____ Robitussin (100 mg/5ml): dosage _____           | frequency _____ | reason _____ |
| _____ Sudafed/Phenylephrine (10 mg/tab): dosage _____ | frequency _____ | reason _____ |
| _____ Tums: dosage _____                              | frequency _____ | reason _____ |
| _____ Tylenol tablets (500 mg/tab): dosage _____      | frequency _____ | reason _____ |
| _____ Tylenol liquid (160 mg/5ml): dosage _____       | frequency _____ | reason _____ |

**Doctor Information:**

Dr. \_\_\_\_\_

Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Hospital Preference: \_\_\_\_\_

Hospital Phone: \_\_\_\_\_

**Dentist Information:**

Dr. \_\_\_\_\_

Phone: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

**Insurance Information:**

Medical Insurance: \_\_\_\_\_

Insurance Policy#: \_\_\_\_\_

Phone: \_\_\_\_\_

Policy holder: \_\_\_\_\_

I, the undersigned, do hereby authorize officials of Shannon Forest Christian School to contact directly the persons named on this document and do authorize the named physicians to render such treatment as may be deemed necessary in an emergency for the health of said child. In the event physicians, other persons named on this document, or parents cannot be contacted, the school officials are hereby authorized to take whatever action is deemed necessary in their judgment, for the health of aforesaid child.

I hereby give permission for the health room personnel to administer the medication I have indicated above.

I will not hold Shannon Forest Christian School financially responsible for the emergency care and/or transportation aforesaid child.

Signature: \_\_\_\_\_ Relationship: \_\_\_\_\_ Date: \_\_\_\_\_