The Church Christian Academy Emergency Contact Form

Student's Name	Date of Birth
Address _____ _____	
Father's Name	Home Phone _____ Cell Phone _____
Father's Employer	Work Phone _____
Mother's Name	Home Phone _____ Cell Phone _____
Mother's Employer	Work Phone _____

Additional Emergency Contacts if Parents Can't be Reached			
Call Order	Name	Relationship to Student	Phone Number
Call First			
Call Second			
Call Third			

Does your child have health care insurance (CHIP, Medicaid or Private) coverage?

☐ Yes ☐ No

Health Insurance Company _____

Group/Policy Number _____

Name of Insured _____

*** Attach a copy of both the front and back of your health insurance card to this form to be placed in the student health record.**

Student Health Information			
Check any of the following health Conditions that your child may have:			
	Asthma		Diabetes
	Epilepsy/Seizures		Other conditions: list below
	Food Allergies – List below		
	Drug Allergies – List below		

Please list ALL medications your child is presently taking:

_____
_____
_____
_____
_____
_____

Family Physician's Name _____ Phone Number _____

In case of an emergency, your child will be transported via ambulance to the nearest emergency room. Your signature authorizes The Church Christian Academy to inform emergency personnel of any medical conditions, allergies, and medications listed above. Your signature authorizes the release of this information to emergency personnel.

Signature of Parent or Guardian _____ Date _____