

# JAMES ISLAND CHRISTIAN SCHOOL STUDENT EMERGENCY INFORMATION

Teacher _____
School Year ____ - ____

\*\*\* **IMPORTANT** \*\*\* It is vitally important for the SAFETY AND WELL BEING OF YOUR STUDENT that we have the information requested below in case of an EMERGENCY. Please fill out COMPLETELY AND RETURN TO THE OFFICE. An information sheet is needed for EACH STUDENT. *Notify the school office IMMEDIATELY ABOUT ANY CHANGE IN THIS INFORMATION.*

NAME: \_\_\_\_\_ GRADE: \_\_\_\_\_ DOB: \_\_\_\_\_  

Last
First
Initial

ADDRESS: \_\_\_\_\_ PHONE: \_\_\_\_\_  

Street
City
Zip

SOCIAL SECURITY NO. \_\_\_\_\_ Email \_\_\_\_\_

*12/10/08*

**\* CHECK WHICH PARENT SHOULD BE CALLED FIRST \***

*FATHER OR GUARDIAN:* \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ PHONE: \_\_\_\_\_ Cell \_\_\_\_\_

*MOTHER OR GUARDIAN:* \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ PHONE: \_\_\_\_\_ Cell \_\_\_\_\_

**If parent(s) cannot be reached, please notify (please write relationship by name):**

1. \_\_\_\_\_ Phone \_\_\_\_\_ Cell \_\_\_\_\_

2. \_\_\_\_\_ Phone \_\_\_\_\_ Cell \_\_\_\_\_

**I give permission for the school to administer Tylenol (acetaminophen) and ibuprofen to my child as needed. (ages 12 and above only) Yes \_\_\_\_ No \_\_\_\_ (Under 12 years: Parent must provide medication)**

The following can pick up my child from school:

1. \_\_\_\_\_ 2. \_\_\_\_\_

3. \_\_\_\_\_ 4. \_\_\_\_\_

***The following persons have restricted contact with my child. List name/relation and restriction: (ie: may attend field trips but not leave with child, may not contact child for any reason, etc.)***

1. \_\_\_\_\_ *Restriction* \_\_\_\_\_

2. \_\_\_\_\_ *Restriction* \_\_\_\_\_

List <u>all</u> medications student takes:	Diagnosis/Condition:	Comments/Instructions (also include times medication dispensed at home):
List all physical or emotional problems (non-medicated allergies, eye glasses, bladder control, P.E. limitations):		Comments/Instructions:

STUDENT \_\_\_\_\_ Grade \_\_\_\_\_

Teacher \_\_\_\_\_

Parent(s) name: \_\_\_\_\_

School Year \_\_\_\_\_ - \_\_\_\_\_

**JAMES ISLAND CHRISTIAN SCHOOL**

**ALL ACTIVITY/SPORTS - LIABILITY RELEASE FORM**

In consideration of being accepted by James Island Christian School for participation in All School Activities/Sports, we do for ourselves and for and on behalf of our child participant do hereby release, forever discharge and agree to hold harmless James Island Christian School, its Board, and the teachers/coaches/drivers thereof from any and all liability, claims or demands for personal injury, sickness or death, as well as, property damage and expenses, of any nature whatsoever which may be incurred by the undersigned and the child-participant that occur while said child is participating in the trip or activity.

Furthermore, we hereby assume all risk of personal injury, sickness, death, damage and expense as a result of participation in recreation and work activities involved therein.

Further, authorization and permission is hereby given to said school (or group) to furnish any necessary transportation, food and lodging for this participant.

The undersigned further hereby agree to hold harmless and indemnify said school, its directors, employees, agents and drivers, for any liability sustained by said school as the result of negligent, willful or intentional acts of said participant, including expenses incurred by attendant thereto.

We, the parents or legal guardians of this participant, hereby grant our permission for him (her) to participate fully in the field trip or activity.

\_\_\_\_\_  
Father or Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Mother or Guardian

\_\_\_\_\_  
Date

**EMERGENCY CARE:**

We give permission to the administration of James Island Christian School to obtain emergency medical care in the most expedient manner at any licensed and qualified medical facility if we cannot be reached immediately to give our direction for care by our child's own physician. We authorize medical treatment, including but not limited to emergency surgery or medical treatment, and we assume the responsibility of all medical bills, if any.

Hospital Insurance \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_ Hospital preference \_\_\_\_\_

Insurance Company \_\_\_\_\_ Policy No. \_\_\_\_\_

**Doctor or Dentist to call in emergency: (I understand there is not a licensed nurse on staff to dispense this medication or to give medical aid).**

Physician \_\_\_\_\_ Phone No. \_\_\_\_\_

Dentist \_\_\_\_\_ Phone No. \_\_\_\_\_

\_\_\_\_\_  
Father or Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Mother or Guardian

\_\_\_\_\_  
Date  
6/16/04