

# *Hamilton Heights Christian Academy*



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## MEDICAL INFORMATION

For School Year: \_\_\_\_\_

Student: \_\_\_\_\_

Age: \_\_\_\_\_ Birthday: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Address: \_\_\_\_\_  
City State Zip

Home Phone: \_\_\_\_\_ Parent's Cell Phone: \_\_\_\_\_

Parent's (Mom or Dad) Work Phone: \_\_\_\_\_

Parent's Place of Employment: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Physician (Name, Address, Phone) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Allergies: \_\_\_\_\_  
\_\_\_\_\_

Medical Problems: \_\_\_\_\_  
\_\_\_\_\_

Medication currently taking: \_\_\_\_\_

\*ALL MEDICATIONS (prescribed or over the counter) ARE TO BE ADMINISTERED FROM THE SCHOOL OFFICE.

Will you allow your child to take Tylenol (or a similar substitute pain killer) while at school? \_\_\_\_\_yes \_\_\_\_\_no

Insurance Company: \_\_\_\_\_ Policy Number \_\_\_\_\_

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## **EMERGENCY MEDICAL TREATMENT RELEASE FORM**

for:

Hamilton Heights Christian Academy

For School Year: \_\_\_\_\_

In case of emergency, I give permission for my child, \_\_\_\_\_ to receive medical treatment deemed necessary for the care of and protection of my child while under HHCA's supervision. I understand that my child will be transported to the closest appropriate medical facility for treatment if necessary.

I also give permission for the medical facility's assigned physician to evaluate and treat the condition. It is understood that in some medical situations, the school may need to contact the local emergency resource before contacting the parent, child's physician, and/or other adult acting on behalf the parent.

Parent Signature: \_\_\_\_\_

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

Insurance Company \_\_\_\_\_

Policy Number: # \_\_\_\_\_