THE COVENANT SCHOOL

2011-2012 EMERGENCY MEDICAL FORM & FAMILY CONTACT INFORMATION

TELEPHONE DIRECTORY *(information as it will appear in the 2011-12 Student-Parent-Faculty Directory Addendum)*

Student Last Name _____ Student First Name _____ (Nickname if applicable) _____

Name of Parents (ie: Mr. and Mrs. William E. Smith, IV) _____ Nicknames of Parent (s) (ie: Bill and Susie) _____

Address _____ City _____ State _____ Zip _____ Home Phone _____

Confidential Data (not published):

Student lives with: ☐ both parents ☐ mother ☐ father ☐ host family ☐ guardian *Parents are:* ☐ separated ☐ divorced

MOTHER'S CONTACT INFORMATION:

Cell:_____Work # _____

Email:_____

FATHER'S CONTACT INFORMATION:

Cell:_____Work # _____

Email:_____

EMERGENCY MEDICAL INFORMATION *(must be completed and signed by parent or legal guardian each year)*

Student Full Name: _____ Birth Date: _____

Persons to contact in case of emergency (other than parent):

1) _____
Name *Relation to Student* *Home Phone* *Cell Phone*

2) _____
Name *Relation to Student* *Home Phone* *Cell Phone*

Pediatrician/Physician: _____ Dr. Office Phone: _____

_____
Health Insurance Company Group # Subscriber I.D.

Hospital Preference: ☐ UVA Hospital ☐ Martha Jefferson Hospital ☐ Other _____

MEDICAL HISTORY

Please list any ongoing condition (ex. ADHD or asthma and how it is treated)_____

_____(*continue on back if needed*)

Recent illnesses or operations:_____

Medications(s) taken on regular basis:_____

Medication given by the school nurse or principal designee must include copy of the signed prescription from student's doctor and medicine in original container. (form available on Covenant's website www.covenantschool.org)

ALLERGIES

☐ Seasonal ☐ Environmental ☐ Bee Sting ☐ Peanut ☐ Other foods (list)_____

☐ **A**llergy to medications (list)_____ Are any of these allergies life threatening? ☐ Yes ☐ No

Describe reactions:_____

Does student have an epi-pen? ☐ Yes ☐ No Doctor who treats:_____ Epi-pen provided to school?: ☐ Yes ☐ No

I give permission for my child to receive the following over-the-counter (OTC) medication at the discretion of the nurse or principal's designee (if provided by you, please label with child's name and dosage to be given). You must check boxes below in order for your child to receive these OTC medications. Pre-Kindergarten students must have a completed MAT form on file.

☐ Acetaminophen (Tylenol) ☐ Ibuprofen (Motrin) ☐ Benadryl ☐ Tums ☐ Pepto-Bismol ☐ cough drops ☐ cough syrup

Other (list)_____

PARENTAL PERMISSION: IN THE EVENT OF A MEDICAL EMERGENCY INVOLVING MY CHILD, I AUTHORIZE COVENANT SCHOOL TO TAKE NECESSARY MEASURES TO HAVE MY CHILD TREATED OR CALL 911. IT IS UNDERSTOOD THAT EVERY REASONABLE EFFORT WILL BE MADE TO CONTACT ME AND/ OR MY CHILD'S PHYSICIAN. I ACKNOWLEDGE THAT I WILL BE RESPONSIBLE FOR THE COST OF TREATMENT. I ALSO GIVE PERMISSION FOR PERTINENT MEDICAL INFORMATION TO BE SHARED WITH FACULTY OR STAFF ON A NEED-TO-KNOW BASIS.

***Parent / Legal Guardian Signature:** _____ *Date*:_____

ALERT NOW 2011-12 EMERGENCY NOTIFICATION SYSTEM *(communicates school closings, urgent messages, emergencies)*

_____ _____ _____ _____
Student Name *Grade* *Parent/Guardian Signature* *Date*

(CONTACTS: List in order of contact preference. Check the box at right that identifies each contact)		Mom home	Mom cell	Mom work	Mom email	Dad home	Dad cell	Dad work	Dad email	Host phone	Host email	Other
Alert 1 phone:		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	_____
Alert 1 email:		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	_____
Alert 2 phone:		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	_____
Alert 2 email:		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	_____
Alert 3 phone:		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	_____
Alert 3 email:		☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	_____