



STUDENT/CHILD MEDICAL FORM

Please complete a new Medical Form for each child (including infants/toddlers) each school year.

Family _____

Date of form completion _____

Child's Full Name _____ Age _____ Date of Birth _____

Nickname (if commonly used) _____ Birth Gender _____

ALLERGIES: please list allergies and reactions.

NO ALLERGIES

Allergy: _____

Reaction: _____

Allergy: _____

Reaction: _____

Allergy: _____

Reaction: _____

- Life-threatening reaction to this allergy is likely/probable*
- Moderate to severe (but not life-threatening) reaction is likely/probable
- This child carries/uses an epi-pen

ASTHMA: please complete this section if this child has asthma.

NO ASTHMA

This child carries or uses an inhaler. List inhaler medication and dose instructions: _____

Exercise induced asthma only/no inhaler is prescribed for this child.

OTHER:

NONE

Medical diagnosis (i.e. diabetes, epilepsy, joint/ligament disorder, etc.): _____

List any medications/equipment, does, prescribing physician for the above listed diagnosis: _____

Surgeries, hospitalizations, or significant injuries in the last 3 years: _____

In the event that this child experiences symptoms related to an above listed condition/diagnosis, I request the following course of action (check all that apply):

- Contact one of the guardians and advise him/her of the situation.
- Contact emergency medical assistance by calling 911*.
- Treat the symptoms in the following way (describe in details each symptom/condition and treatment, using an additional page if necessary): _____

* Note – If you indicate that a life-threatening reaction is likely, we will call 911 if symptoms appear, whether or not the “contact emergency medical assistance” box is checked. The child’s parent/guardian will be responsible for all incurred medical charges including EMS.

Parent/Guardian Initials: _____



STUDENT/CHILD MEDICAL FORM

Please complete a new Medical Form for each child (including infants/toddlers) each school year.

Family _____

Date of form completion _____

I have included on this form a complete statement of medications, procedures, or other interventions that are required in the event of an emergency; and I will provide all medications, inhalers, injectors, or other necessary items whenever the above listed child is participating in Hope Academy classes, field trips, or other Hope Academy functions.

I acknowledge and agree that, while Hope Academy will attempt to take appropriate actions if such situations occur, Hope Academy is not a medical facility and cannot be held liable for any reaction or resulting injury. By enrolling my child in Hope Academy, I acknowledge and accept the risks of injury associated with my child's pre-existing condition(s) while participating in Hope Academy activities. Furthermore, I acknowledge and accept the risks of injury or harm associated with intervention and/or treatment performed by ministry workers.

Accordingly, I agree on behalf of myself and my child, to indemnify, defend, and hold harmless Hope Academy/Hope Bible Church, and its agents, employees, volunteers, and other representatives for injury arising directly or indirectly out of the described medical needs of my child.

Provide any additional comments, clarification, or direction below:

I agree that the above information is complete and accurate to the best of my knowledge, and I agree to the terms and conditions of this medical form.

Printed name of parent/guardian: _____

Signature of parent/guardian: _____ Date: _____

Primary Contact: _____

Secondary Contact: _____

Phone: _____

Phone: _____

Alternate Phone: _____

Alternate Phone: _____

List names and contact numbers for all adults authorized to pick up this child. Use a blank page for more space if needed.

Name Phone Alt. Phone Relationship

Name Phone Alt. Phone Relationship

Name Phone Alt. Phone Relationship

Name Phone Alt. Phone Relationship

Please submit a copy of the child's most current immunization records no later than Back to School Night.

OFFICE USE ONLY: Student Immunizations Received Date _____