

LINCOLN CHRISTIAN SCHOOL

Consent For Medical Care

2011/2012 Academic School Year

STUDENT INFORMATION

Last Name		First Name		Middle Name		Grade	
Street Address			City	State	Zip	Teacher (if Pre-K – 5 th)	
Cell Phone Number		Home Phone Number		Social Security Number		Date of Birth	
Known drug allergy? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list: _____							
Known food/substance/chemical allergy? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list: _____							
List any medical conditions or needs your child has: _____							
List ALL current medications, inhalers, epipens, etc: _____							

EMERGENCY CONTACTS (please number boxes with contact preference 1 – 8)

Father/Legal Guardian's Name		<input type="checkbox"/>	Work Phone	<input type="checkbox"/>	Cell Phone		
Mother/Legal Guardian's Name		<input type="checkbox"/>	Work Phone	<input type="checkbox"/>	Cell Phone		
Other Contact	Relation to Student	<input type="checkbox"/>	Work Phone	<input type="checkbox"/>	Cell Phone		
Other Contact	Relation to Student	<input type="checkbox"/>	Work Phone	<input type="checkbox"/>	Cell Phone		
Doctor's Name		Office Phone		Dentist's Name		Office Phone	
Medical/Health Insurance Name				Address			
Policy Holder: _____		Policy Number: _____		Policy Phone: _____			

AUTHORIZATION & RELEASE FOR MEDICAL CARE TO STUDENT

I, the undersigned parent or legal guardian(s) of _____ (“Student”), authorize designated representatives of Lincoln Christian School, d/b/a Willie George Ministries, Inc. (“the School”) to give first aid and treatment to Student in the case of emergency, injury or illness. If I cannot be reached to consent to offsite medical treatment, I authorize Student to be transported to and treated at an offsite medical facility at the discretion of the School. I understand that I am personally and solely responsible for payment of all costs of medical treatment. I agree to not sue the School or its directors, officers, employees, agents and volunteers for any reason whatsoever (even if they are negligent) for any harm or injury to Student resulting from said medical treatment. I personally assume all risks and liabilities related to Student's medical treatment and agree to indemnify the School, its directors, officers, employees, agents and volunteers from any claims or liabilities which might be assessed against any of them as a direct or indirect result of said medical treatment.

AUTHORIZATION TO ADMINISTER NON-PRESCRIPTION MEDICATION

(Grades Pre-K – 5 require additional verbal authorization by parent/legal guardian)

I, the undersigned parent/legal guardian(s), give permission to the authorized representatives of Lincoln Christian School to administer the following non-prescription medications to Student, as needed:

Acetaminophen (Tylenol)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ibuprofen (Advil)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Antacids	<input type="checkbox"/> Yes <input type="checkbox"/> No
Topical First Aid Ointments	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cough Drops	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Authorizing Father/Legal Guardian's Signature	Date
Authorizing Mother/Legal Guardian's Signature	Date

PLEASE NOTE: LCS STUDENTS CANNOT ATTEND SCHOOL WITHOUT THIS COMPLETED FORM ON FILE.