FULL ARMOR CHRISTIAN ACADEMY

MEDICAL INFORMATION FORM 21-22

Please fill out completely.

Students Last Name:		First Name:
Date of Birth:	Grade:	Gender: M / F
EMERGENCY INFORMATION:		
Father's Name & Phone:		Mother's Name & Phone:
Health Insurance Company:		Group #:
Name of Physician to be called in emergency: Phone#:		
Name of Dentist to be called in emergency: Phone#:		

If needed, I authorize the Full Armor Christian Academy office to Administer the following medication as requested by my student, not to exceed the recommended dosage>

Yes No Acetaminophen (generic) Dosage:

Yes No Ibuprofen (generic) Dosage:

I wish to be contacted each time my child requests medication before it is administered.
Yes No

By signing this section, you are authorizing the distribution of these over the counter medications for minor pain.

Parent's Signature: Date:

_____ _____

EMERGENCY CONTACT INFORMATION

In case of emergency or serious illness, we request the school contact us first. If we are not available, please contact the designated emergency contact. If the emergency contact cannot be reached, the school has our permission to make whatever arrangements deemed necessary for our child/(ren's) treatment. If the emergency is life threatening and we cannot be reached, the physician has permission to act accordingly absolving the school of any liability.

Name of Emergency Contact: _____ Phone(s) _____
Contact's Relation to student: _____

Name of Emergency Contact: _____ Phone(s) _____
Contact's Relation to student: _____

FULL ARMOR Christian Academy

MEDICAL INFORMATION FORM 20-21

Has your child ever received treatment for or been diagnosed with any medical condition?

(Heart trouble, seizures, asthma, etc.) Yes No

If yes, please list and explain:

_____

Does your child have any skin sensitivity to injected or oral medication? Yes No

If yes, please list and explain:

_____

Does your child have any allergies to food, common chemicals, environmental allergens, etc.? Yes No

If yes, please list and explain:

_____

Does your child have Diabetes? Yes No (Circle one) Type 1 Type 2

Comments _____

Does your child have any other medical conditions that we need to be aware of? Yes No

If yes, please list and explain:

_____

Does your child take daily medications at home? Yes No

If yes, please specify: _____

Does the school need to administer medication for your child? Yes No

If yes please specify, and speak with administration and teacher.

_____

Does your child wear glasses? Y N If yes, please explain when to be worn: _____

When was last eye exam?

_____

Does your child have normal hearing? Y N If no, please explain accommodations:

When was last hearing screening?

_____