Bethlehem Christian Academy

MEDICAL REPORT

STUDENT NAME_____

MOTHER NAME_____DAY PHONE_____

FATHER NAME_____DAY PHONE_____

EMERGENCY CONTACT IF UNABLE TO REACH PARENTS:_____

HOSPITAL PREFERENCE_____

PHYSICIAN'S NAME_____PHONE_____

PLEASE INDICATE BELOW IF YOU HAVE ANY OF THE FOLLOWING CHRONIC ILLNESSES OR CONDITIONS:

- ☐ ALLERGIES
- ☐ ASTHMA
- ☐ CONVULSIONS
- ☐ DIABETES
- ☐ EAR INFECTIONS
- ☐ HEARING LOSS
- ☐ HEART DISEASE
- ☐ LEUKEMIA
- ☐ EPILEPSY
- ☐ SICKLE CELL
- ☐ CEREBRAL PALSY
- ☐ OTHER
- ☐ MEDICATIONS: Please List_____ Dosage_____

MEDICATION ADMINISTRATION

ANY MEDICATION GIVEN TO MY CHILD WILL BE AUTHORIZED BY MY SIGNATURE ONLY

PARENT/ GUARDIAN SIGNATURE_____

DATE_____

EMERGENCY CARE

I GIVE PERMISSION TO THE ADMINISTRATION OF BETHLEHEM CHRISTIAN ACADEMY TO OBTAIN EMERGENCY MEDICAL CARE IN THE MOST EXPEDIENT MANNER AT ANY LICENSED QUALIFIED MEDICAL FACILITY IF I CANNOT BE REACHED IMMEDIATELY TO GIVE DIRECTION FOR THE CARE BY MY CHILD'S PHYSICIAN.

PARENT/ GUARDIAN SIGNATURE_____

DATE_____