HEALTH/EMERGENCY RECORD

HERITAGE CHRISTIAN SCHOOL

5412 67th Ave. W., University Place WA 98467 Phone: (253) 564-6276 Fax: (253) 460-1695 www.heritagecs.net

Student Name: ______________________________ Date of Birth: ______________

Age: ______________ Entering Grade: __________ Gender: ______________

Address: ________________________ City: ______________ Zip: ________

Parent: ____________________ Cell Phone:______________ Work Phone: ____________

Parent: ____________________ Cell Phone: ______________ Work Phone: ____________

Medical History: Please check all conditions that apply to your Child. Please give a brief explanation and instructions.

EXPLANATION / SPECIAL INSTRUCTIONS

__ Allergies to medication
__ Allergies (other) ________________________________
__ Asthma ________________________________
__ Attention Deficit Disorder (ADD) ________________________________
__ Attention Deficit and Hyperactivity ________________________________
__ Disorder (ADHD) ________________________________
__ Blood disease ________________________________
__ Diabetes ________________________________
__ Emotional problems ________________________________
__ Epilepsy/Convulsions ________________________________
__ Frequent headaches ________________________________
__ Frequent stomach aches ________________________________
__ Frequent nosebleeds ________________________________
__ Glasses/contact lenses ________________________________
__ Hearing impairment ________________________________
__ Heart abnormality ________________________________
__ Nervousness ________________________________
__ Physical disability ________________________________
__ Sinus problems ________________________________
__ Other (please specify) ________________________________

Date of last Tetanus Shot: __________

List all medications your Child is taking: ________________________________

Does your Child have limitations that impact his/her ability to participate in the School's programming, including its PE classes and athletic events)? ________________________________

Alternate Contacts: Please list at least two alternate persons to contact if parents/guardians cannot be reached.

Name	Phone	Relationship to Student	Permission to pick up Child?
			Yes No
			Yes No
			Yes No
			Yes No

Medical Providers: Please provide information for your Child's medical providers.

Name	Address	Phone
Doctor:		
Dentist:		

Medical Insurance.
I understand that I am responsible for the costs of medical care for my Child while my Child is enrolled in the School. All students attending Heritage Christian School are recommended to have adequate medical insurance coverage. The School does not assume responsibility for such coverage. Please provide the insurance company and policy number for your Child below.

Insurance Company: ____

Group No.: ______________________ ID No.: __________________________

Authorization To Treat And Obtain Medical Care.
I, the parent or legal guardian of the above-identified student (my "Child"), authorize Heritage Christian School (the "School") and its agents and designated healthcare providers to administer first aid care and treatment to my Child while at School and any School-related activities or events.

If illness or injury should occur, I authorize the School to obtain emergency treatment (including, but not limited to, medical, dental and hospital care) for my Child. I understand that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required. I also recognize and understand that the School will endeavor consult with me concerning the reasons for, and effects of, all such care prior to obtaining such care. Recognizing that it may be difficult to reach me, I authorize the School to permit

commencement of treatment and to execute any necessary documents required prior to treatment, when, in the professional judgment of the treating medical provider, such treatment is deemed medically necessary, even if I have not yet been consulted. In authorizing such emergency treatment, I agree to accept the medical

professional's determination that the treatment rendered was medically necessary to protect the life, health, or mental well-being of my Child. I acknowledge and agree that I am responsible for any expenses incurred by my Child in obtaining and receiving such treatment.

Authorization To Share Health Information.
I authorize the School to release to, and obtain from, any treating hospital, clinic, licensed medical facility, or attending healthcare provider, my Child's health information for purposes of diagnosis, treatment, care, or prognosis of any medical problem. I further authorize the School to confer (telephonically, in person, electronically, or otherwise) with such professionals.

I understand and agree that the School consists of a team of faculty members and administrators at the School who collaborate with respect to my Child's educational experience. As part of this collaborative effort, I understand and agree that the School may share my Child's health information with other School employees on a "need-to-know" basis, including, without limitation, in cases of health and safety emergencies; when there is concern about my Child's ability to function academically, emotionally, physically, or mentally within the School environment; or when legal requirements demand that confidential information be revealed.

Waiver Of Liability.
I agree, on my own behalf and that of my Child and our heirs, executors, administrators, personal representatives, and/or assigns ("Releasors"), to forever release, acquit, discharge, covenant to hold harmless and covenant not to sue the School, its trustees, employees, volunteers, representatives, and agents ("Releasees") from any and all claims, suits, liabilities, and actions, including, but not limited to, any negligence (but not for willful or wanton conduct) of the Releasees, which Releasors may have, now or in the future, which arise directly or indirectly out of any authorized first aid and emergency treatment of my Child. I further agree, on behalf of myself and my Child, to indemnify and hold harmless the Releasees against any and all demands, claims, suits, actions, causes of action, or liabilities, covered by the above release.

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I have read this form in its entirety and understand what it means. By signing this form, I affirm that I have legal custody of my Child and am authorized to sign on my Child's behalf.

Parent/Guardian #1 Signature:_____________________________________Date:______________

Printed Name:____

Parent/Guardian #2 Signature:_____________________________________Date:______________

Printed Name:____