

BILLINGS CHRISTIAN SCHOOLS
NEW STUDENT MEDICAL AND EMERGENCY INFORMATION

TO PARENTS/GUARDIANS OF CHILDREN ENROLLING IN BILLINGS CHRISTIAN SCHOOLS:

We at Billings Christian Schools respect your right to privacy. We also want to assure you that the information being requested will only be shared on a "need-to-know" basis and only when it is necessary to do so. We are requesting this information so that we may better care for your child.

PLEASE READ CAREFULLY

An up-to-date immunization record must be furnished by the child's physician. Students participating in sports must also have an athletic physical exam that must also be on file with Billings Christian Schools.

Please Print or Type

Date: _____

Student's Full Name _____
Last First Middle

Address _____ Zip Code _____

Male Female Date of Birth _____ Age: _____

EMERGENCY INFORMATION:

Please provide the names of individual to contact if parent or guardian cannot be reached for a medical emergency:

1. Name: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

2. Name: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

MEDICAL INFORMATION

Hospital/Emergency Room Preference

(Please Note: If your insurance coverage requires (of if you prefer) a specific provider (Clinic, Physician, Dentist, HMO), please furnish the provider's name and phone number as follows :)

___ Billings Clinic ___ Saint Vincent's

Name of student's Physician _____ **Phone Number** _____

Name of student's Dentist _____ **Phone Number** _____

Allergies (Check if applicable)

1. Bee Sting Needs medication at school and medical follow-up Yes ___ No ___

2. Food Name of food(s) _____

Needs medication at school and medical follow-up Mild reaction but needs to avoid ingestion

Describe reaction _____

3. List any allergic reactions to medications _____

Asthma

- Needs medication at school Self-administers medication as needed
- No medication needed at school

Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)

- Needs medication at school Taking medication at home only
- Diagnosed but not taking medication

Diabetes

- Insulin dependent Self-manages (snacks, diet, testing, etc.)

Seizures

- Needs medication at school Takes medication at home
- History of seizure but not currently on medication

Hearing Concerns (Please explain) _____

Vision Concerns (Please explain) _____

Physical Restrictions

- Uses Mobility Aide (wheelchair, crutches, walker, etc.)

Operations, Accidents, Illnesses

What operations, serious accidents or serious illnesses has the student had? _____

Current Medications

Is the student currently taking any medication (prescription or over-the-counter)? ___ Yes ___ No

If yes, please specify: _____

Mental or Psychological Conditions

Has the student been diagnosed with any mental or psychological condition requiring medication or medical management? ___ Yes ___ No. If yes, please explain: _____

NOTE: Parents/Guardians must complete a Medication Consent Form and be willing to follow the medication policy before medication will be given at school. This form is available from the school office.

Immunization Records ~*~ *Documentation by a physician or clinic indicating dates of immunization is required. Documentation must be on file with Billings Christian Schools before he/she will be allowed to attend school.* ~*~

In case of accident or serious illness, I request Billings Christian Schools contact me. If Billings Christian Schools is unable to contact me, I hereby authorize a representative of Billings Christian Schools to obtain emergency medical aid for my child. It is also understood that this form will be valid as long as my child is enrolled and any medical expenses will be assumed by the parent or guardian. I understand it is my responsibility to update information on this form as necessary.

Parent or Legal Guardian’s Signature _____ Date _____