Permission for Emergency Treatment

Cinco Christian School

26 Yacht Club Dr. NE, Ft. Walton Beach, FL 32548
850-243-7515 www.cincoschool.org

Student's Name______________________________ Parent/Guardian Name___________________________

Student's Grade_____________________ Teacher's Name_________________________________

Mother/Guardian Cell #__________________ Work #___________________

Father/Guardian Cell #___________________ Work #___________________

On rare occasions an emergency requiring hospitalization, surgery, and/or other medical treatment develops. Since in some countries/states students under 21 years might not be administered an anesthetic or operated upon without the written consent of the parent/guardian, we request the parent/guardian sign the following statement. This is to prevent a dangerous delay in case an emergency does occur and we are unable to contact the parent/guardian. The designated supervisor of this activity will attempt to contact the parent/guardian prior to exercising the emergency treatment consent. In the event of injury and/or illness to our son/daughter/ward, ______________________, born,____________________,
Student Name Month/Day/Year
We hereby authorize a school representative to obtain and give consent to whatsoever medical treatment the representative deems necessary, including the administration of an anesthetic and surgery, and do hereby release the Cinco Christian School Representative, Cinco Christian School, and Cinco Baptist Inc. from any and all claims which may arise from the representative's obtaining and consenting to said medical treatment.

____________________ ________________________ ___________________________________
Date Telephone Number Signature of Parent/Guardian

________________________ ____
Emergency Number Emergency Contact Person (other than parent or guardian)

STATE OF FLORIDA
COUNTY OF OKALOOSA
The foregoing instrument was acknowledged before me this_______ by_____________________________
Date Name of Person Acknowledged

who is personally known to me or who has produced____
Type of Identification

as identification and who did/did not take an oath.

______________________________________ ___________________________________
Signature of Person Taking Acknowledgment Name of Acknowledger Printed Stamp

Cinco Christian School
Medical Information

Student Data

Name	Grade	Date of Birth (Month/Day/Year)	School Year
Address	City	Home Phone:	

PLEASE CHECK ALL CURRENT CONDITIONS:

____ Allergy
____ (specify:____________)
____ Anemia
____ Anemia-Sickle Cell
____ Asthma
____ Cancer
____ Cerebral Palsy
____ Diabetes
____ Ear Infection-Repeated
____ Gastrointestinal Condition
____ Headaches-Frequent or Migraine (circle)
____ Hearing Impaired
____ Hypoglycemia
____ Hernia

____ Heart Abnormality
(specify:____________)
____ Hypertension
____ Kidney Disease/Problems
____ Leukemia
____ Muscular Dystrophy
____ Motor/Physical Impairment
____ (specify:____________)
____ Scoliosis
____ Seizure Disorder
(specify:____________)
____ ADD (Attention Deficit)
____ ADHD (Hyperactivity)
____ Requires Glasses/Contacts
____ Requires Hearing Aids
Other:____________

PLEASE IDENTIFY ANY OTHER SPECIAL NEEDS OR CONCERNS THAT WOULD NECESSITATE CHANGES IN YOUR STUDENT'S LEARNING ENVIRONMENT:

____
____
____
____
____
____

PLEASE LIST ALL MEDICATIONS CURRENTLY BEING TAKEN
(Home)____________________
(School-see below)____________________

MEDICATION TO BE TAKEN AT SCHOOL:
If it is necessary for your child to take prescription medication during school hours, a parent or guardian must complete a Dispersion of Medication Form and bring the medication to the front office. All medication must be in its original container and be labeled with the student's name, including inhalers. The first dosage of any new medication shall not be administered during school hours due to the possibility of an allergic reaction. Parents must provide necessary equipment and supplies needed to administer medication

SCHOOL HEALTH SERVICES:
Since a nurse is not available for diagnosis and treatment of injuries, only basic first aid will be administered and parents will be notified. In the event of a life threatening emergency, 911 will be called.

Preferred Physician:____________ Phone:____________
Preferred Hospital:____________ Phone:____________

Should an emergency occur and parent/guardian, emergency contacts, and preferred physician cannot be reached, may any available doctor be used:
____Yes ____No If No, what procedures would you wish followed?
____
____

Additionally I/We will not hold Cinco Christian School or representative financially responsible for the emergency care and/or transportation for said child.

______________________________ ______________________________
PARENT/GUARDIAN SIGNATURE **DATE**