Christian Liberty Academy
502 W. Euclid Ave., Arlington Heights, IL 60004
Health Office Phone# (847) 385-2014 Health Office Fax# (847) 385-2062

2019-2020
Health Emergency Form

TO BE COMPLETED and SIGNED BY PARENT OR GUARDIAN BY THE FIRST DAY OF SCHOOL.

Student's Name: ____ Gender: ☐ Male ☐ Female
(FULL LEGAL NAME) **Last Name** **First Name** **FULL Middle Name**

Student's Date of Birth: ____________________ Grade Level: ________ Language spoken at home: ____________________

Student's Cell Phone (_____)_____-__________ Student's Email ______________________________

Home Address: ____ Home Phone: (____)_____-________

Name of Father: __________________________ Cell Phone: (____)_____-________ Work Phone: (____)_____-_________

Email that you check often: ____

Name of Mother: __________________________ Cell Phone: (____)_____-_________ Work Phone: (____)_____-________

Email that you check often: ____

Name of responsible adult who will assume responsibility for child if parent/legal guardian cannot be reached:

Emergency Contact #1: __________________________ relationship to student: __________ Cell Phone: (____)_____-________

Emergency Contact #2: __________________________ relationship to student: __________ Cell Phone: (____)_____-________

Physician Name: ____ Phone Number (_____)_____-_________

Dentist's Name: ____ Phone Number (_____)_____-_________

Hospital Name: ____ Phone Number (_____)_____-_________

Insurance : ☐ Yes ☐ No Insurance Provider: ______________________________ Policy # ______________________
Name of insured person: ______________________________________

In the event that your child is injured or requires emergency treatment and a parent or guardian is unable to be contacted, it is imperative that you sign the emergency release below to authorize treatment and care for your child:

EMERGENCY RELEASE

****IMPORTANT****

PARENT OR LEGAL GUARDIAN MUST SIGN THIS RELEASE

I hereby authorize Christian Liberty Academy, its employees and agents, to provide emergency medical assistance or to arrange for and consent to on my behalf immediate medical treatment by a licensed or certified physician or other medical personnel for my child whenever the authorized school personnel believe such emergency medical assistance is necessary to protect the health, safety, and welfare of my child. I further waive any claims against Christian Liberty Academy, its employees and agents arising out of the provision or arrangement for emergency medical assistance to my child and agree to hold harmless and indemnify Christian Liberty Academy, its employees and agents, either jointly or severally, from and against any and all liability, including attorneys' fees, resulting and arising out of the provision of or arrangement for emergency medical treatment. By signing this document, I give permission for my child's health information to be shared as necessary.

PARENT OR GUARDIAN MUST SIGN HERE :

PARENT / GUARDIAN SIGNATURE: ____ **DATED:** ____________

 Student Name:_______________________________________

HEALTH HISTORY

Indicate Yes or No to all. Please indicate details on all that you have answered yes to:

Allergies? (please list if yes) ☐Yes ☐No	ADD/ADHD? ☐Yes ☐No
Asthma? ☐Yes ☐No	Orthopedic Condition? ☐Yes ☐No
Anemia? ☐Yes ☐No	Concussion? ☐Yes ☐No
Bleeding Tendency? ☐Yes ☐No	Mental Health Problem? ☐Yes ☐No
Diabetes? ☐Yes ☐No	Seizures/Convulsions? ☐Yes ☐No
Ear Infections? ☐Yes ☐No	Sickle Cell Anemia? ☐Yes ☐No
Gastrointestinal Condition? ☐Yes ☐No	Speech Disorder? ☐Yes ☐No
Hearing Problem? ☐Yes ☐No	Wears Glasses or Contacts? ☐Yes ☐No
Chronic Heart Condition? ☐Yes ☐No	Other?

Does your child take medication? ☐Yes ☐No Name(s) of medication(s) ________________________________

Reason given: ________________________________ Time(s) medication(s) taken*: ________________

History of serious illness / injury / hospitalization / surgery? ☐Yes ☐No If yes, please explain: ______________________
____
____

Does your child have a history of frequent absences from school? ☐Yes ☐No If yes, please explain: __________________
____

ADMINISTRATION OF MEDICATION AT SCHOOL – POLICY IN ACCORDANCE WITH ISBE REGULATIONS:

The purpose of administering medication in school is to help each student maintain an optimal state of health to enhance his or her education. The administration of medication to students should be discouraged unless absolutely necessary for the student's health. **The responsibility for administering student medication rests solely with the parents, or guardian:** thus a schedule should be arranged so that all medication is taken at home under parental supervision and not during, school hours. It is a courtesy of Christian Liberty Academy to assist in a student's well-being and health. In exceptional cases when medication must be taken during the school day, the regulations from the State of Illinois will be implemented by the school nurse. This shall not prohibit any school employee from providing emergency assistance to students.

- **All medications, prescriptions or over-the-counter, must contain a signed doctor's statement** indicating the name of the medication, patients (student's) name and correct dosages and time to be given. See *Medication Authorization Form.* No medication will be given without a doctor's order.
- Parents must bring all medications to the health office. Over-the-counter medications will not be stocked.
- Medications must be brought in their original container.
- Medicine will not be shared with other students.
- **Students *must not have possession* of prescription or non-prescription (over-the-counter) medications at school** with the exception of these emergency medications: an inhaler or Epi-pen *with a completed Medication Authorization Form that includes a doctor's signature.*
- The school nurse and/or school administrator may, at their discretion, reject requests for administration of medication. It is understood that the school provides this service in the interest of the well-being of students and as an accommodation to parents.

THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE AND I HAVE READ THE MEDICATION POLICY AND UNDERSTAND THAT I NEED TO SUBMIT A DOCTOR'S ORDER FOR ANY MEDICATION THAT I WANT GIVEN TO MY CHILD DURING SCHOOL HOURS. Signature of Parent/Guardian:________________________________