Brooklake Christian School
Medical History / Emergency Consent Form

Student Information

Name: ____ Sex: ❑ Male ❑ Female
Last First Middle

Address: ____
Street City Zip

Age: _________ Birth Date: ________________ Grade Entering: ________

Lives with: ❑ Both parents ❑ Father ❑ Mother ❑ Guardian ❑ Other (explain)

Father/Stepfather/Guardian's Name: ____________________________________

Address: (if different from student) ____________________________________

Home Phone: _______________ Work Phone: _________________ Cell/Pager #: _________________

Mother/Stepmother/Guardian's Name: ____________________________________

Address: (if different from student) ____________________________________

Home Phone: _______________ Work Phone: _________________ Cell/Pager #: _________________

Emergency Information

____
Doctor's Name Phone Number Preferred Emergency Care Facility

____
Dentist's Name Phone Number Preferred Dental Facility

❑ Allergies (meds or other) __________________ ❑ Date of last tetanus booster __________________

❑ Asthma __________________________________ ❑ Other ____________________________________

Medications being taken ____

CONSENT FOR HOSPITAL ADMISSION AND/OR PHYSICIAN'S CARE

Medical and Surgical Consent
I, the undersigned, hereby consent to all medical and surgical treatment by the attending physician and to the administration for performance of all examinations, administering of medicine, treatments, anesthetics, operations, x-rays, or other procedures which may be deemed necessary during the stay at this medical facility for ____ (student's name).

Financial Agreement
I hereby agree to accept responsibility for any financial indebtedness incurred during the hospitalization. I agree to pay for all necessary services at the current rate and in case of collection, pay reasonable attorney's fees and collection expenses.

I have read the above consent form and understand and agree to its content.

Parent Signature: ____ **Date:** _________

Parent Signature: ____ **Date:** _________

Medical History – This side is confidential information seen only by the school nurse.

____

Student Name | Date of Birth /Age | Today's Date

Date of last physical exam: ________________________________

Does your child have now or previously had any of the following? If YES, explain briefly on line provided.

	YES	NO	
Allergies to medication	❑	❑	List: ______________________
Other allergies	❑	❑	List: ______________________
Frequent headaches	❑	❑	______________________
Convulsions/seizures	❑	❑	______________________
Hearing impairment	❑	❑	______________________
Visual impairment	❑	❑	______________ Date of last eye exam: ________
Frequent ear infections	❑	❑	______________________
Asthma	❑	❑	______________________
Hay fever	❑	❑	______________________
Chronic bronchitis	❑	❑	______________________
Sinus problems	❑	❑	______________________
Heart abnormality	❑	❑	______________________
Frequent stomach aches	❑	❑	______________________
Frequent constipation	❑	❑	______________________
Frequent diarrhea	❑	❑	______________________
Kidney disease	❑	❑	______________________
Blood disease	❑	❑	______________________
Frequent nosebleeds	❑	❑	______________________
Diabetes on insulin	❑	❑	______________________
Hypoglycemia	❑	❑	______________________
Thyroid disease	❑	❑	______________________
Arthritis	❑	❑	______________________
Orthopedic injuries	❑	❑	______________________
Skin problems	❑	❑	______________________
ADD	❑	❑	______________________
ADHD	❑	❑	______________________
Emotional problems	❑	❑	______________________

Any other health problems or physical challenges which make participation difficult in classroom or physical activity:

____

____

List any medications being taken:

____

____

Does your son/daughter have any special needs or problems that should be known to better care for and meet his/her needs?

____

____

Girls only:

Age when periods started __________

Any menstrual problems ______________________________________