Grade____________

Fort Myers Christian School
1550 Colonial Blvd.
Ft. Myers, FL 33907

New Student 2010 - 2011 EMERGENCY CARE MEDICAL FORM

Student=s Full Legal Name:

____ __________________________

Last First Middle Social Security Number

Date of Birth________/________/________

Father: Natural/Step/Foster (please circle one) Home Phone____________________

____

Name Place of Employment, Occupation Phone at Work cell or beeper

Mother: Natural/Step/Foster (please circle one)

____

Name Place of Employment, Occupation Phone at Work cell or beeper

GUARDIAN: (if different from above)

____

Name Place of Employment, Occupation Phone at Work cell or beeper

Family Physician _________________________________ Phone ________________________

Family Dentist___________________________________ Phone_________________________

Preferred hospital ____

Please check if student has any of the following:

Diabetes______ Asthma______ Kidney Disease______ Heart Disease______ Seizures (convulsions)______

Wears Glasses______ Vision problem other than glasses____________________________ Hearing Aid______

Ear problems__________________________________ Allergies____

Any other conditions requiring special observation____

Current medications: (include name, amount, and frequency)

____

Insurance company covering child ____ Policy Number ________________

In case of an accident or illness where immediate treatment is not needed, but where my child is unable to remain at school, I request the school to contact me. If I cannot be reached, I request that one of the persons listed below be contacted to care for my child until I can be reached. Persons who will care for student in case parent cannot be reached: MUST BE FILLED OUT (please print)

Name: ________________________ Relationship ____________ Phone: (home)______________ (Work)______________

Name: ________________________ Relationship ____________ Phone: (home)______________ (Work)______________

Parent=s Statement:

AI accept responsibility for notifying the school of any changes of home or business address and phone numbers. In the event of serious illness or accident and I cannot be immediately contacted, I give my permission to have my child moved by ambulance or other conveyance to a doctor=s office or hospital for immediate attention. I also assume responsibility for payments of same. If, in the opinion of a properly licensed and practicing physician, my child needs medical or surgical services which require my consent before being supplied, and I cannot be reached, I hereby authorize, appoint, and empower the Principal or his designee, to furnish on my behalf such written or oral authorization as may be so required. Further, I release the Principal, his designee, FMCS, and First Assembly of God from any liability which might arise from the giving of such authorization. It is my desire that my child be furnished with medical or surgical services as soon as reasonably possible after the need arises.@***TO BE SIGNED IN THE PRESENCE OF A NOTARY PUBLIC ONLY***

________________________________/_____________________________ ______________

Signature of Parent/Guardian D.L. # Date

STATE OF _______________ COUNTY OF ______________________

On the _____________ day of ___________________________, 20 _________, before me came

____, known to me and/or produced valid identification as documented above and who executed the foregoing instrument and acknowledged that he executed the same in my presence.

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Notary Public (over)