

Student's Information

Student's Name: _____
Last
First
Middle
Suffix

Preferred Name: _____ Title: _____ Grade Level: _____

Date of Birth: _____ Gender: _____ SSN: _____

Allergies: _____ Custody Issue Church Affiliation: _____

E-Mail Address: _____

Primary Family Information

Address Line 1: _____

Address Line 2: _____

City
State
ZIPCode
County

Home Phone 1: _____ Listed Phone 2: _____ Listed

Father's Information

Father's Name: _____
Last
First
Middle
Suffix

Preferred Name: _____ Title: _____ Marital Status: _____

Mobile Phone: _____ Church: _____ Home E-Mail: _____

Company Name: _____ Job Title: _____

Business Phone 1: _____ Ext. _____ Emergency Contact: Tag: _____

Phone 2: _____ Ext. _____ Allowed to pick up child: License: _____

Business E-Mail: _____

Mother's Information

Mother's Name: _____
Last
First
Middle
Suffix

Preferred Name: _____ Title: _____ Marital Status: _____

Mobile Phone: _____ Church: _____ Home E-Mail: _____

Company Name: _____ Job Title: _____

Business Phone 1: _____ Ext. _____ Emergency Contact: Tag: _____

Phone 2: _____ Ext. _____ Allowed to pick up child: License: _____

Business E-Mail: _____

1) Emergency Contacts and Pickup Information

Emergency Contacts (Emergency Contacts other than Parents)

First Name: _____ Last Name _____

Home Phone: _____

Emergency Contact: _____ Relation: _____

Business Phone: _____ Mobile Phone: _____

Allowed to pick up child: _____ Tag: _____

DL#: _____

Notes: _____

2) Emergency Contacts and Pickup Information

Emergency Contacts (Emergency Contacts other than Parents)

First Name: _____ Last Name _____

Home Phone: _____

Emergency Contact: _____ Relation: _____

Business Phone: _____ Mobile Phone: _____

Allowed to pick up child: _____ Tag: _____

DL#: _____

Notes: _____

3) Emergency Contacts and Pickup Information

Emergency Contacts (Emergency Contacts other than Parents)

First Name: _____ Last Name _____

Home Phone: _____

Emergency Contact: _____ Relation: _____

Business Phone: _____ Mobile Phone: _____

Allowed to pick up child: _____ Tag: _____

DL#: _____

Notes: _____

Medical Contacts

Physician: _____ Phone Number: _____

Dentist: _____ Phone Number: _____

Hospital: _____ Phone Number: _____

Insurance: _____ Phone Number: _____

Policy Number: _____

Previous School Information

School Attended Last year: _____ Address: _____

Circle Grades Previously Attended At CCA: K4 K5 1 2 3 4 5 6 7 8

Check Primary Way Home: Carline After School Care:

Medical Waiver

As parent/ legal guardian of _____, I do hereby authorize my consent to any X-ray, examination, anesthetic, medical or surgical diagnosis rendered under general or special supervision of any licensed medical staff member under the provision of the Medical Practice Act. It is understood that this authorization is given in advance of any specific diagnosis or treatment being required but is given to provide authority and power to render care which the aforementioned physician, in his or her best judgment, may deem advisable. It is understood that effort shall be made to contact me, the undersigned, prior to rendering treatment to my child, but that any of the above treatments will not be withheld if I cannot be reached. I agree to be responsible for paying any charges that may be incurred by such treatment. I hereby release Central Christian Academy of Martin, Tennessee, its staff, and representatives from any liability for accidents or injury sustained by my child in conjunction with any event.

Signature of Parent/Legal Guardian: _____ Date: _____

Date of most recent Tetanus or DPT immunization: _____

Is this child on any medication? Yes No

If so what? _____

Does this child have any allergies? Yes No

Please list allergies and reactions: _____

Please list any other medical information or physical problems: _____

Additional Pickup List

The following people have permission to drop off/pick up my child in the event that I cannot.

<u>Name</u>	<u>Relationship</u>	<u>Phone number</u>
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

Parent/Legal Guardian Signature: _____ Date: _____

CCA "At Risk" Policy

CCA will NOT release my child to someone who appears to be incapacitated or aggressive for any reason. If a "pick-up" person is suspected of this behavior, CCA staff will notify me to pick up my child to ensure their safety. If I, the parent, is the one showing signs of diminished capacity, a person on my child's pick-up list will be contacted to pick up my child. I understand that if I insist on taking my child with me while in this state of duress, the police will be called to intercept and arrest me for endangering my child. CCA is seeking to provide the safest environment for my child and I agree to abide by this policy statement.

Parent/ Legal Guardian Signature: _____ Date: _____

CCA Photograph Release

I hereby grant permission to CCA to take photographs of my child while practicing in school activities. I understand that these photos may appear in forms such as, display panels, teacher-made books, DVDs, CCA website, Facebook and other forms of advertisement used to market CCA. I also understand that I am to receive no compensation for my child's appearance. I also understand that my child's participation confers on me no ownership rights to the photographs or negatives whatsoever.

Parent/ Legal Guardian Signature: _____ Date: _____

CCA Anaphylaxis Treatment Plan

Student Name: _____ Date of Birth: _____

Has the student had an Anaphylactic reaction? Yes No

What is the child allergic to? Dairy Peanuts Tree Nuts
Eggs Soy Wasp Stings
Fish Shellfish Bee Stings

Other: _____

Has the student been educated on signs and symptoms of anaphylactic reaction and able to notify adult if experiences these symptoms? Yes No

If exposed to allergen do you administer Benadryl before using EpiPen/EpiPen Jr?
Yes No

School Policy: All school nurses will use epi-pen trainer and teach school staff, who are willing to administer the Epi-Pen, in the event a child has a severe allergic reaction. All teachers or staff that are trained will sign the Epi-Pen in-service form. The form will be kept in the school nurse office. If a student has an Epi-Pen for allergies to bee or wasp stings, the Epi-Pen needs to go out on the playground with the teacher or staff member who will administer the device. If a student goes on a field trip the Epi-Pen must accompany the student in the medications bag. Also, it should be noted in the substitute folder that a student in the class has severe allergies and the location of the Epi-Pen should be documented.

Choose student dose: EpiPen Jr. 0.15mg EpiPen 0.30mg

Upon administration, 911 will be called (along with parent) and transported to nearest Emergency department. A second dose of EpiPen/EpiPen Jr may be given, if available, if EMS has not arrived or symptoms of anaphylaxis has not abated after 15 minutes.

Do you agree with the above treatment plan? Yes No

If you answered no, please make modifications to this protocol regarding the indications and mode of treatment. Please specify medications ordered, the administration, and disposition of child in detail. Please use a separate sheet of paper if necessary. (NOTE: If requesting Benadryl please state dose and if to be given before or after EpiPen/EpiPen Jr injection.)

Parent/Legal Guardian Signature: _____ Date: _____

Phone: _____ Alternate Phone: _____
Primary Care Physician: _____ Phone: _____
Teacher: _____ Grade: _____

Authorization for Administration of Non-Prescription Medicine

This request is to be effective for the school year _____ or earlier stop date: _____

Students name: _____ Date of Birth: _____

Medication _____

Generic Name (If Used): _____

Dosage Amount: _____ Please administer, according to manufacturer's label for recommended time schedule, when needed at school for the following conditions or symptoms:

I request the designated school personnel to assist my child in the administration of the above described medication. I give permission for my child to take this medication at school. I understand that: (1) there is no liability on the part of Central Christian Academy, its personnel, or agents for civil damages as a result of the administration of this medication to my child when the person administering the medication acts as an ordinarily reasonably prudent person would have acted under the same or similar circumstances; (2) this medication should be brought to the school only by a responsible person; (3) this medication must be in its original labeled container; (4) this medication will be destroyed if it is not picked up within one week following the above stop date or one week after the close of the current school year, whichever occurs first.

Parent/Legal Guardian Signature: _____ Date: _____

Address: _____ Home Phone: _____

Work Phone: _____

Non- prescription medication requests must be renewed by the parent/guardian and a release signed by the parent/guardian annually, each medication, or any change in medication, requires a new form. The parent/ guardian will be responsible for ensuring that medicines provided for the school have not expired.