

The Rockbridge Christian Academy

First Aid and Emergency Medical Care

DATE: _____

GRADE: _____

Student's Name _____

Date of Birth _____

Birthplace _____

Parent / Guardian Name(s) _____

Home Address _____

Home Phone _____

Father: _____ Employer: _____ Phone: _____

Mother: _____ Employer: _____ Phone: _____

Responsible Relative or Friend: _____ Phone: _____

Family Physician: _____ Phone: _____

Address: _____

Family Dentist: _____ Phone: _____

Address: _____

Insurance: _____ Policy #: _____

Address: _____

The following are facts concerning my child's medical history including allergies, medication being taken, and any physical or emotional impairment to which medical personnel should be alerted. (Please include allergic reactions to any medication or drugs. Use back of form if necessary.)

If my child becomes ill or is injured, please proceed with first aid and emergency medical care. I understand the school will make every effort to contact me in case of such and emergency.

Parent or Guardian Signature

Both parents and/or guardian must sign

Parent or Guardian Signature

NOTE: Each enrolled child must have this form in his or her cumulative folder to meet enrollment requirements. Please complete a separate form for each child.