NORTHLAND CHRISTIAN SCHOOL

STUDENT MEDICAL INFORMATION

Student Name_____Grade_____

Name of Parent 1_____Phone #_____

Name of Parent 2_____Phone #_____

Emergency Contact_____ Phone #_____

Doctor Name: _____Phone #: _____

Dentist Name: _____Phone #: _____

Insurance Company: _____ Phone #: _____

Policy #: _____ Group #: _____ ID #: _____

Name of Insured: _____ Employer: _____

Please Check	Condition	Comments
	Allergies (food, drug, insect)	
	Allergies (seasonal)	
	Asthma	
	ADD/ADHD	
	Diabetes	
	Hearing/Vision problems	
	Heart problems	
	Seizures	
	Spinal issues	
	Other	

Medication	Dose	Frequency

I ( ) give ( ) do not give Northland Christian School permission to provide over the counter medications to my student.

As a Parent or Legal Guardian, I authorize a Northland Christian School teacher, coach or administrator to have the above named student examined by a qualified physician or dentist, and in the event of injury to administer any emergency care he deems necessary to ensure proper treatment. Every effort will be made to contact a parent or guardian to explain the nature of the problem prior to any involved treatment. In signing this form as a parent or guardian, I hereby agree to relieve the school and/or its officers of any liability for injury or accident occurring on the school premises, while on a field trip or athletic competition trip.

Parent/Guardian Signature_____**Date**_____