

TRI-CITY CHRISTIAN ACADEMY
A Ministry of Tri-City Baptist Church
 2211 West Germann Road • Chandler, Arizona 85286-6799
 (480) 245-7902

EMERGENCY INFORMATION

STUDENT

Full Name: _____ Grade: _____ Birthdate: _____

FATHER (or Legal Guardian):

Full Name: _____ Home Phone: _____

Home Address: _____

Business Name: _____ Business Phone: _____

Cell Phone: _____ Pager: _____ Other Contact Number: _____

MOTHER (or Legal Guardian):

Full Name: _____ Home Phone: _____

Home Address: _____

Business Name: _____ Business Phone: _____

Cell Phone: _____ Pager: _____ Other Contact Number: _____

IF PARENT OR GUARDIAN CANNOT BE REACHED, CONTACT:

Full Name: _____ Relationship to Student: _____

Home Address: _____ Home Phone: _____

Business Phone: _____ Cell Phone: _____ Other Number: _____

Full Name: _____ Relationship to Student: _____

Home Address: _____ Home Phone: _____

Business Phone: _____ Cell Phone: _____ Other Number: _____

PHYSICIANS:

Doctor's Name: _____ Phone: _____

Dentist's Name: _____ Phone: _____

I authorize the following individuals to collect my child from the facility:

Name:	Home Address (#, street, city)	Home Phone:
Name:	Home Address (#, street, city)	Home Phone:
Name:	Home Address (#, street, city)	Home Phone:

HEALTH HISTORY:

Has your child ever had or does he/she currently have any of the following?

YES	NO		YES	NO		YES	NO	
___	___	Allergy to Bee Stings	___	___	Heart Murmur	___	___	Pneumonia
___	___	Anemia	___	___	Hepatitis	___	___	Polio
___	___	Arthritis	___	___	Hernia	___	___	Rheumatic Fever
___	___	Asthma	___	___	Hives	___	___	Scoliosis
___	___	Chicken Pox	___	___	Kidney Trouble	___	___	Sinus Trouble (severe)
___	___	Concussion	___	___	Measles	___	___	Sore Throats (chronic)
___	___	Convulsions	___	___	Menstrual Cramps	___	___	Tuberculosis
___	___	Diabetes	___	___	(severe)	___	___	Valley Fever
___	___	Eczema	___	___	Migraine Headaches	___	___	Whooping Cough
___	___	Emotional Problems	___	___	Mononucleosis	___	___	Epilepsy
___	___	Frequent Fainting	___	___	Mumps	___	___	Other _____

Medical conditions (Indicate operations, injuries, prolonged absences):

Allergies to medications: _____

Other allergies: _____

Is the student now under medical treatment? _____ If yes, please state reason and doctor's name. _____

Important: List all medications your student takes on a regular basis. _____

Tri-City Christian Academy will have the following over-the-counter medications available for the **unforeseen** needs of all students. Please check off the medications you approve for your child during the school day, administered by a staff member, dosed as indicated on the medicine container (**NOTE: TCA keeps a very limited supply of medications on-hand. If you foresee a medicinal need for your child, such as after an orthodontist appointment, or when your child is getting over an illness, please send the appropriate medicine to school with your child. The office staff or your child's teacher will dispense the medicine as needed.**):

YES	NO		YES	NO	
___	___	Chewable Tums	___	___	Regular Tylenol (ages 8-12)
___	___	Extra Strength Tylenol (ages 12 and up)	___	___	Ibuprofen (ages 12 and up)
___	___	Cough Drop	___	___	Chewable Children's Tylenol (ages 4-8)
___	___	Benadryl	___	___	Call Parents

I hereby acknowledge myself to be the parent or guardian of the above named student at Tri-City Christian Academy, and I give my consent to the school for my child to attend any school sponsored activity or sports event in which he/she is a part. I hereby authorize the Tri-City Christian Academy staff members to call an ambulance, if they feel it is necessary, and authorize any licensed physician, nurse, or hospital to render such medical treatment to my child that they may deem necessary and/or desirable. I am signing this statement in the presence of a notary public as witness of my acknowledgement.

GUARDIAN SIGNATURE: _____ **DATE:** _____

STATE OF: _____ **COUNTY OF:** _____

On this _____ day of _____, 20____, before me personally appeared _____ (name of signer) whose identity was proved to me on the basis of satisfactory evidence to be the person whose name is subscribed to this document, and who acknowledged that he/she signed the above document.

NOTARY SIGNATURE: _____ **SEAL:** _____

MY COMMISSION EXPIRES: _____