

Prince of Peace Christian School
4000 Midway Road
Carrollton TX 75007
972-447-9887
972-447-0877

School Year 2010-2011

Student Name _____
Grade: _____

EMERGENCY CONTACTS

(Please furnish two names OTHER THAN PARENTS)

Name of Contact #1 _____
Home Phone _____ Cell Phone _____

Name of Contact #2 _____
Home Phone _____ Cell Phone _____

AUTHORIZATIONS

I. Standard practice in an emergency is to transport child to the nearest hospital. We keep notarized Plano Presbyterian Authorization Forms on file for emergencies.

II. These persons are allowed to pickup my child at Prince of Peace Christian School.

Name _____ Driver's License# _____
Name _____ Driver's License# _____
Name _____ Driver's License# _____

Note: If your child's normal transportation is unavailable, please call the school office with the social security or driver's license # of the person who will be picking up your child. This is required when the school and/or child may not know the individual providing transport.

III. My child has permission to take over the counter medications, as indicated below, to be administered per label directions.

_____ Children's Tylenol _____ Ibuprofen _____ non-drowsy cold/allergy medication
_____ Extra Strength Tylenol _____ Aleve _____ upset stomach relief
_____ anti-itch Cream

IV. I give permission for my child to be photographed for editorial, promotional, and audiovisual presentations by Prince of Peace Christian School. I consent to the reproduction and the use of these photographs.

Yes _____
No _____

Parent Signature _____ Date _____
Driver's License # _____

Parent Signature _____ Date _____
Driver's License # _____

Prince of Peace Christian School
Student Health Information
2010-2011

Your child's health history is important to help us assess him/her in case of sudden illness or injury. The information you record on this form will become a part of your child's school health record and may be shared within the school to the school staff. Please complete the following information and return it to the school

Student's Name _____ Date of Birth _____
 Teacher/Advisor _____ Grade _____

Please circle Yes or No:

Yes	No	Allergies to Medications	Yes	No	Hyperactive Behavior or
Yes	No	Other Allergies	Yes	No	Attention Deficit Disorder
Yes	No	Reactive to insect bites/stings	Yes	No	Emotional problems
Yes	No	Asthma or lung problems	Yes	No	Vision/eye problems
Yes	No	Seizures or neurological problems	Yes	No	Hearing/ear problems
Yes	No	Fainting	Yes	No	Speech/language processing problems
Yes	No	Headaches	Yes	No	Severe injuries
Yes	No	Blood pressure problems	Yes	No	Operations or other hospitalization
Yes	No	Diabetes	Yes	No	Blood Disorders
Yes	No	Tuberculosis: Positive skin test or active disease	Yes	No	Bone/muscle problems (including back problems)
Yes	No	Frequent stomachaches	Yes	No	Chronic dental problems
Yes	No	Heart problems	Yes	No	Other unspecified problems
Yes	No	Kidney/bladder problems			

If you answered "yes" to any of the above, please specify the problem, symptoms, cause if known, age of onset, and treatment. If your child needs treatment for the condition(s) at school, please specify on this form. You will be responsible for bringing medication to school for use by your child.

Does your child take any medication routinely? Yes _____ No _____

Name of Medication	Dosage	How Often?	To be taken at school?	
_____	_____	_____	Yes _____	No _____
_____	_____	_____	Yes _____	No _____

Can your child participate in Physical Education classes? Yes _____ No _____

If not, please specify the reason:

Parent Signature _____ Date _____

Presbyterian Hospital of Plano
6200 W. Parker Road (Parker and Midway)
Plano TX 75093
214-608-8000

AUTHORIZATION FOR EMERGENCY MEDICAL CARE

My/our signature(s) on this authorization indicates that I/we give permission for the emergency evaluation and treatment of my/our child in my/our absence by a licensed physician at Presbyterian Hospital of Plano. I/we accept responsibility for any and all expenses incurred during the treatment of the child listed below.

Child's Name _____ Date of Birth _____

Allergies _____

Date of Last Tetanus Boosters _____

Pertinent Medical History

Signature of Parent/Guardian

Signature of Parent/Guardian

State of Texas, Collin County

Subscribed and sworn to before me this _____ day of _____, 2010.

Notary Public
In and For the State of Texas

My Commission Expires _____



Legal Guardian _____ Relationship _____

Address _____

City/State _____ Zip _____

Home Phone _____ Business Phone _____

Date of Birth _____ SSN _____ Employer _____

Close Friend _____ Phone _____

Guarantor's Insurance in Name of _____

Insurance Company _____

Employer _____

Contract Number _____ Group Number _____

Teacher/Advisor _____

**Field Trip Release Form
2010-2011**

(PS-5th - Please return to your child's teacher. MS/HS - Please return to respective offices.)

This form will be used during the school year to provide emergency information for drivers and volunteers accompanying Prince of Peace Christian School students.

Student Name _____

Parent/Guardian _____

Emergency Number _____

Emergency Contact (Please furnish two names other than parents)

Name of Contact #1 _____

Home Phone _____ - _____ Cell Phone _____ - _____

Name of Contact #2 _____

Home Phone _____ - _____ Cell Phone _____ - _____

Authorization

In the event that I/we cannot be reached to make arrangements for emergency medical attention, I/we authorize Prince of Peace Christian School to take my child to the nearest hospital.

Yes My child has permission to take over-the-counter pain reliever (Acetaminophen/Ibuprofen) as needed
 No for pain, to be administered by an adult teacher/chaperone.

Medical Information

If your child needs any medication or has any condition that a volunteer needs to be aware of, please let below (i.e. allergies, asthma, etc.)

Authorized Signature:

Parent/Guardian

Date

Grade _____

**2010-2011
MEDICATION INFORMATION**

Complete this form only if your child needs to take prescription or non-prescription medication while at school.

Child's Name _____
Name of Medication _____
Dates to be Administered _____
Time to be Administered _____
Amount to be Administered _____

Note on Prescription Medication: Medication must be in the original container labeled legibly with the child's name, a date, directions, and the physician's name and telephone number. The school will not administer medication after the expiration date. Medications must be administered by the school nurse or office staff.

Note on Non-Prescription Medication: Medication must be labeled with the child's name and the date the medication was brought to the school. Non-prescription medication must be in the original container. The school will not administer after the expiration date. The school must administer it according to the label directions if approved in writing by the child's parent.

Print Name

Signature of Parent/Guardian
approving administration of medication

The following documentation will include date given and initials of staff that administered. (Key to initials: SJ=Sue Jewett,SL =Susan Luehrs, SB=Sherri Bloom, Sbi=Susan Bitting, ST=Sheryl Townes, MB=Meredith Brady, JL=Joyce Lonquist, CM=Claudia Mercher)

Nurse's Notes

