

# Broadfording Christian Academy

## Student Emergency, Health & Pickup Information Sheet

**This form Must be turned into school prior to your child's attendance!!!**

**Copies of any Legal Child Custody information should also accompany this form!**

**List 1 child per form ONLY! PLEASE PRINT ALL INFORMATION!**

Child's Name: \_\_\_\_\_ Age: \_\_\_\_\_ Grade: \_\_\_\_\_ Date: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Cell Phone Number: \_\_\_\_\_  
Mother's Address: \_\_\_\_\_ Home Phone #: \_\_\_\_\_  
Mother's Address: \_\_\_\_\_ Work Phone #: \_\_\_\_\_  
Mother's Email Address: **PLEASE PRINT** \_\_\_\_\_

Father's Name: \_\_\_\_\_ Cell Phone Number: \_\_\_\_\_  
Father's Address: \_\_\_\_\_ Home Phone #: \_\_\_\_\_  
Father's Address: \_\_\_\_\_ Work Phone #: \_\_\_\_\_  
Father's Email Address: **PLEASE PRINT** \_\_\_\_\_

List up to 3 people (other than Parents) who would most likely pick up this child from school:

The following people also have my permission to administer this child's medication while my child is in their care. ( Please note that this box must be checked for this statement to be applicable.)

NAME:	Relationship:	Phone #:	Cell Phone #:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**If anyone other than the people named above would need to pick up this child from School or Extended Care, the parent/guardian will need to give a note to the Teacher upon arrival to school that day.**

**The person picking up the child should come prepared to show their drivers license to the Teacher or Extended Care Staff.**

Doctor: \_\_\_\_\_ Tel.: \_\_\_\_\_ Dentist: \_\_\_\_\_ Tel.: \_\_\_\_\_

Please check if your child has any of the following:

Asthma     Seizure disorder     Attention Deficit     Diabetes     Heart Problems  
 Vision Problems     Wears Contacts     Wears Glasses     Hearing Problems     Uses Hearing Aid

Allergies To: \_\_\_\_\_ Describe Allergic Reactions: \_\_\_\_\_

Food \_\_\_\_\_  
Medications \_\_\_\_\_  
Insect Bites \_\_\_\_\_  
Hay Fever \_\_\_\_\_  
Sensitivity to Chemicals \_\_\_\_\_  
Environmental Allergies \_\_\_\_\_

List any other information regarding your child's health: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List any medications your child takes regularly and the reason.

Medication	Hours taken	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____

**IF ANY OF THESE MEDICATIONS MUST BE TAKEN AT SCHOOL WE MUST HAVE A COMPLETED PHYSICIAN'S MEDICATION ORDER FORM ON FILE IN THE HEALTH OFFICE. THESE ORDERS MUST BE RENEWED EVERY YEAR. MEDICATIONS MUST BE IN THEIR ORIGINAL, LABELED, CONTAINER.**

Please enter the following insurance information:

Child's Primary Insurance Provider: \_\_\_\_\_ Policy #: \_\_\_\_\_  
Name of Policy Holder: \_\_\_\_\_ Member #: \_\_\_\_\_

**I understand that if this list changes it is my responsibility to replace the current form on file.**

**In the event I cannot be reached, I authorize Broadfording Christian Academy to make emergency medical care decisions on behalf of my child named above. I understand that Broadfording Christian Academy will not be responsible for any medical expenses incurred if medical attention is obtained. I also authorize BCA to contact my child's physician and request any information needed to provide accurate medical data required by the state of Maryland. Please see the BCA student handbook for the complete medical disclaimer being consented to.**

Parent / Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_