

KING'S VALLEY CHRISTIAN SCHOOL

4255 Clayton Road ♦ Concord, California ♦ 94521-2761 ♦ (925) 687-2020 ♦ FAX (925) 687-7829 ♦ www.kvcs.com

MEDICAL RELEASE & EMERGENCY INFORMATION

PLEASE PRINT:

CHILD'S NAME:	BIRTHDATE:	GRADE:
ADDRESS:	CITY:	ZIP:
MOTHER'S NAME:	HOME PHONE:	
FATHER'S NAME:	HOME PHONE:	
CHILD LIVES WITH: MOTHER FATHER BOTH PARENTS ALTERNATES OTHER:		
WHICH PARENT SHOULD BE CONTACTED FIRST IN CASE OF AN EMERGENCY:		

Doctor's Name and Phone Number: _____ Preferred Hospital: _____

Health Insurance including Policy Number: _____

Medical conditions we should be aware of (e.g. asthma, diabetes, migraines, allergies): _____

LIST ALL MEDICATION(S) WITH DOSAGE(S) (1) _____

(2) _____ (3) _____

Specific instruction for emergency treatment: _____

Please indicate any physical condition that would limit participation in physical education class _____

LIST AT LEAST TWO PERSONS, IN ADDITION TO PARENTS, whom we may contact in an emergency; and who can take your child from the campus. Your child will not be allowed to leave with any other person without written authorization from parent or guardian. Please inform the office of any special circumstances restricting parent contact with this student. If for any reason a parent is not allowed to pick up this student, the office must have legal documentation on file.

RELATIONSHIP	NAME	DAYTIME PHONE	CELL PHONE OR OTHER #
1. MOTHER			
2. FATHER			
3.			
4.			
5.			
6.			
7.			
8.			

This is to certify that I, the undersigned, am legally responsible for the above-named child and authorize King's Valley Christian School, for the duration of the time my child is enrolled, to take my child to a physician for the performance of anesthetics and whatever medical ministrations, major or minor, may be necessary or advisable in the event of an emergency. I also agree to accept responsibility for the cost of medical services. I understand that a conscientious effort must be made to notify me (parent/guardian) before such action will be taken.

I authorize KVCS to administer a non-aspirin pain reliever, such as Tylenol, to my child if deemed necessary. Yes _____ No _____
(please initial)

Father's Signature

Mother's Signature

Guardian's Signature

Date

This form must have **TWO** signatures unless the child is in the legal custody of one parent only.

ADDITIONAL CONTACT INFORMATION

RELATIONSHIP	NAME	DAYTIME PHONE	CELL PHONE OR OTHER #
9.			
10.			
11.			
12.			
13.			
14.			
15.			
16.			