



Good Shepherd Christian Academy Summer Care Medical Information 2011

Child's Name: _____ Age: _____ Grade: _____

In case of an emergency, or if your child needs to be sent home due to illness: (please make sure they are within 30 minutes)

Parent's Name: _____

Parent's Name: _____

Home Phone: _____

Home Phone: _____

Work Phone: _____

Work Phone: _____

Cell Phone: _____

Cell Phone: _____

Please list 2 emergency contacts, NOT including parents that must be able to pick up within 30 minutes:

Name: _____

Name: _____

Relationship: _____

Relationship: _____

Home Phone: _____

Home Phone: _____

Work Phone: _____

Work Phone: _____

Cell Phone: _____

Cell Phone: _____

Doctor Name: _____

Dentist Name: _____

Doctor Phone: _____

Dentist Phone: _____

Allergies: (example) adhesive or paper tape, band aides, medications, food, bee stings etc. **List reaction** your child has.

List all medication your child is currently taking.

Seasonal Allergies: Type, reaction and treatment.

Health Problems: (example: diabetes, high blood pressure, asthma (if asthmatic, does your child have an inhaler?))

If your child complains of a headache, toothache, muscle ache, stomach ache, etc. do you grant permission to the school to administer any of the following:

	Yes	No	Dosage	x's/day
A. Tylenol regular or extra strength	_____	_____	_____	_____
B. Motrin	_____	_____	_____	_____
C. Advil (Ibuprofen)	_____	_____	_____	_____
D. Children's Tylenol	_____	_____	_____	_____
E. Other _____	_____	_____	_____	_____

*** All medication must be in original containers. Prescription medication must be in pharmacy container, labeled and prescription form completely filled out and signed. If child has asthma or serious allergy that requires epipen an action plan must be completed * before start date.**

Parent's Signature

Date