KEMPTON NEW CHURCH SCHOOL

583 Hawk Mountain Rd. – P.O. Box 140 – Kempton, PA 19529 – society@kncs.org – 610-756-6140

2016-2017

HEALTH INFORMATION

STUDENT NAME_____ Grade ____ Birthdate_____

Address_____

Home phone number _____

FATHER	MOTHER
Name _____	Name _____
Cell phone number_____	Cell phone number_____
Work phone number _____	Work phone number _____
Place of employment _____	Place of employment _____

Emergency contact/s if parent/s can't be reached:

Name _____ Phone number _____

_____ _____

For anonymous data requested by our school district, please circle whichever of the following conditions apply to your child.

Arthritis/Rheumatic Disease; Asthma; Attention Deficit Disorder/Hyperactivity; Bleeding Disorder & Cooley's Anemia; Cardiovascular Condition; Cerebral Palsy; Cystic Fibrosis; Diabetes Type I; Diabetes Type II; S pina Bifida Epilepsy and Other Seizure Disorders; Sickle Cell Anemia; Tourette's Syndrome; Life-Threatening Food Allergies

May your child be administered the following over-the-counter medications?

Ibuprofen *(Advil)* – Age 12 and up	Yes ☐ No ☐	Acetaminophen *(Tylenol)* – Age 5 and up	Yes ☐ No ☐
Triple-antibiotic ointment	Yes ☐ No ☐	Gold Bond anti-Itch cream *(no steroids)*	Yes ☐ No ☐
Menthol cough drops *(such as Halls)*	Yes ☐ No ☐	Homeopathy *(for bumps, insect stings, etc.)*	Yes ☐ No ☐

Child's weight for proper dose of acetaminophen and/or ibuprofen _____

My child is seriously allergic to (food, drugs, bee stings, etc.):

_____

My child has the following health condition/s and/or is taking the following medications, which may be relevant in the case of an emergency:

_____

_____

CONSENT for EMERGENCY MEDICAL TREATMENT

The law requires parental permission for medical procedures on minors. This consent form will help KNCS avoid unnecessary delays in getting treatment for a student in serious need. No major operations will be performed, *except in an emergency,* without parents being contacted and fully informed.

I hereby give permission to representatives of the Kempton New Church School to allow medical personnel to perform accepted procedures for the diagnosis and treatment deemed necessary for my child *in the case of a medical emergency.* KNCS representatives may release to health care providers any health information regarding my child that may prove relevant to his/her immediate care.

Parent Signature _____ **Date** _____