EAST HILL CHRISTIAN SCHOOL
ANNUAL FIELD TRIP RELEASE AND EMERGENCY MEDICAL FORM

I give permission for _____; Grade_____ to participate in all sports and school sponsored trips away from the school premises throughout the current school year. Students will be accompanied by a teacher and will be under adequate supervision.

Although the school desires to provide a safe and enjoyable time for all students, accidents can still happen. I/we understand that there are risks/dangers involved with participation in off-campus trips and their associated activities. In consideration of my child being allowed to participate in this event, I/we assume responsibility for those ordinary and reasonable risks associated with the travel and activities. I/we agree to hold harmless East Hill Christian School, its affiliated organizations, employees, agents any representatives, including volunteer and other drivers, from any and all claims arising from my child's participation.

In case of an accident, illness or other emergency, I/we request that the school contact me/us. If the school cannot reach a parent/guardian after conscientious effort, I/we give permission for school staff to call licensed paramedics, physician or dentist. If a life-threatening emergency exists I/we give permission for school staff to call paramedics immediately and to contact me/us as soon as possible thereafter.

I/we authorize and consent to any X-ray, examination, anesthetic, medical, dental or surgical diagnosis or treatment, and hospital care which is in the best judgment of a licensed physician or dentist, is deemed advisable. I/we also agree to be financially responsible for emergency medical transportation.

_____ _____

Father/Guardian's Signature Date Mother/Guardian's Signature Date

(PRINTED)_____ (PRINTED)_____

**If the child lives with both parents, the release must be signed by both parents/guardians.

ADDRESS:_____HOME NUMBER:_____

Father' work #_____Cell # _____e-mail:_____

Mother's work #_____Cell #_____e-mail:_____

In case of emergency, please list persons we should contact if we are unable to contact you at the above listed numbers:

NAME:_____Relationship:_____#_____

NAME:_____Relationship:_____#_____

PHYSICIAN:_____#_____

DENTIST:_____#_____

PREFERRED HOSPITAL:_____

HEALTH INSURANCE CARRIER:_____POLICY #_____

Under the name of:_____Relationship to Student:_____

SWORN TO AND SUBSCRIBED BEFORE ME THIS _____DAY OF _____,_____.

_____

NOTARY PUBLIC, STATE OF FLORIDA

PLEASE BE SURE TO FILL OUT BOTH SIDES OF THIS DOCUMENT

STUDENT HEALTH HISTORY

STUDENT:_____DOB:_____AGE:_____SEX:_____

Parent's or guardian's Permission: I certify that this information is true and I consider him/her physically capable of participating in school activities and/or athletics. I understand that this history is not a complete one, but a screening for participation in an athletic program. I will bring to the attention of the school staff during the year, any medical problems that might affect his/her health. I authorize the school to obtain, through a physician of it's own choice any emergency medical care that may become necessary for the student in the course of such activities. I also agree not to hold the school or anyone acting in it's behalf, responsible for any injury or emergency treatment of such injuries occurring to the above named student.

List Allergies (including reactions to medications):_____

List Medication being taken on a regular basis:_____

YES	NO	
		Any Asthma, if yes do they use an inhaler:
		Any diabetes, if yes talk to coach and explain emergency procedure.
		Any other chronic illness, if yes explain:
		Any illnesses lasting more than one week:
		Any bleeding tendencies:
		Yellow jaundice:
		Hospitalizations:
		Any surgery other than tonsillectomy:
		Any injuries requiring treatment by a physician:
		Presently taking any mediations, if yes explain:
		Any dizziness, fainting, convulsions, or frequent headaches:
		Ever been knocked out:
		Wear glasses or contact lenses:
		Wear any dental appliances:
		Allergic to any medications, if yes explain:
		Any knee, ankle, neck, or joint injuries:
		Any sprains or dislocations:
		Any broken bones:
		Any organ missing (appendix, eye, kidney, etc.), if yes explain:
		Any heat exhaustion or stroke:
		History of family member under 50 with heart attack or heart problems:
		Have there been any health problems in the last year:
		Any loss of consciousness or severe headaches:
		Do you know any reason why this applicant should NOT participate in sports?

Are there any physical or medical conditions we should know about not already listed:_____

_____

The above named student has my/our permission to take the following medications when needed at school: (Generic forms only)
_____Acetaminophen (Tylenol) _____Ibuprofen (Advil) _____Cough Drops _____Antacid Tablets

**Any prescription medications taken at school need to have appropriate forms (filled out by the doctor) along with the original bottle with students name on it taken to the student office.
***Any non-prescription medications you would like available for your child need to be brought to the student office in a Ziploc bag labeled with students name and appropriate paper work filled out. (Forms available in the student office)

PARENT(S) SIGNATURE:_____DATE_____