

2008-2009
MT. BETHEL CHRISTIAN ACADEMY
INFORMATION SHEET FOR CLASSROOM, FRONT DESK, ASP

Student's Name _____ (____/____/____) Home Phone _____
Birth Date

Address _____
Number Street City Zip Code

Mother's Name Business Phone Cell Phone email address

Father's Name Business Phone Cell Phone email address

Please list three relatives or neighbors who will assume responsibility for your child in the event you cannot be reached.

1. _____	_____	_____	_____
Name (relationship)	Home Phone	Business Phone	Cell Phone
2. _____	_____	_____	_____
Name (relationship)	Home Phone	Business Phone	Cell Phone
3. _____	_____	_____	_____
Name (relationship)	Home Phone	Business Phone	Cell Phone

Child's Doctor _____
Name Address Telephone

Child's Dentist _____
Name Address Telephone

If necessary, your child will be provided basic first aid and medication administration according to school policy (see handbook for medication guidelines). Injury assessment and intervention will include the use of topical skin antibiotic and anti-itch medication as appropriate. Pain relief medication will be administered based upon your child's level of discomfort and nature of the discomfort. Dosage will be determined by your child's weight and/or age.

Consent for Medication: Please circle **YES** or **NO**. Age & weight appropriate dose will be given.

Acetaminophen (Tylenol): YES NO	Bacitracin Oint: YES NO	Decongestant (Sudafed): YES NO
Antihistamine (Allergic Reaction) YES NO	Ibuprofen (Advil): YES NO	Guiatuss DM (Robitussin DM): YES NO
	TUMS: YES NO	Cough/sore throat lozenge: YES NO
	Mylanta: YES NO	

Do you carry family/hospital insurance? _____ Name of Company _____

Hospital of choice _____ Policy # _____ Group # _____

Signature _____ Date _____

STUDENTS WILL NOT BE ALLOWED TO ATTEND CLASS UNTIL THIS FORM IS COMPLETED, SIGNED AND RETURNED TO THE SCHOOL OFFICE.