

**BAY AREA CHRISTIAN SCHOOL MEDICAL RELEASE FORM
PLEASE PRINT ALL INFORMATION**

STUDENT'S NAME _____ GRADE _____ TEACHER _____

DATE OF BIRTH _____ SEX: _____ MALE _____ FEMALE _____

STUDENT'S CELL NUMBER _____ HOME PHONE _____ E-MAIL _____

STREET ADDRESS _____ CITY _____ STATE _____ ZIP _____

MOTHER'S NAME _____ MOTHER'S E-MAIL _____

MOTHER'S STREET ADDRESS _____ CITY _____ STATE _____ ZIP _____

MOTHER'S HOME PHONE _____ MOTHER'S CELL PHONE _____

FATHER'S NAME _____ FATHER'S E-MAIL _____

FATHER'S STREET ADDRESS _____ CITY _____ STATE _____ ZIP _____

FATHER'S HOME PHONE _____ FATHER'S CELL PHONE _____

LIST TWO NEIGHBORS OR NEARBY RELATIVES WHO WILL ASSUME TEMPORARY CARE OF THE STUDENT IF YOU CANNOT BE REACHED IN THE EVENT OF ILLNESS OR ACCIDENT.

1. _____
NAME AND RELATIONSHIP TO STUDENT _____ HOME PHONE _____ WORK/CELL PHONE _____

2. _____
NAME AND RELATIONSHIP TO STUDENT _____ HOME PHONE _____ WORK/CELL PHONE _____

OUR CHILD IS ALLERGIC TO THE FOLLOWING MEDICATIONS: _____

OUR CHILD HAS A HISTORY OF THE FOLLOWING MEDICAL CONDITIONS: _____

OUR LOCAL MEDICAL ADVISORS ARE:

NAME: _____ PHONE: _____

MEDICAL INSURANCE CARRIER _____

POLICY NO. _____ CERTIFICATE NO. _____

IN THE EVENT OF AN EMERGENCY, I HEREBY AUTHORIZE BACS OFFICIALS TO SECURE MEDICAL TREATMENT. I UNDERSTAND THE STUDENT IS GENERALLY TRANSPORTED BY AMBULANCE TO THE NEAREST EMERGENCY CARE FACILITY, AND THAT I AM FINANCIALLY RESPONSIBLE FOR THE EMERGENCY CARE AND/OR TRANSPORTATION FOR SAID STUDENT.

I ALSO AUTHORIZE BACS TO TRANSPORT MY CHILD TO SCHOOL RELATED EVENTS.

SIGNATURE OF PARENT OR GUARDIAN (REQUIRED)

DATE

RELEASE FOR MEDICATION

*WE HAVE NON-PRESCRIPTION MEDICATION AVAILABLE IN THE SCHOOL OFFICE AS A TEMPORARY HELP FOR YOUR CHILD. IF YOU WOULD FOR THESE TO BE GIVEN TO YOUR CHILD, PLEASE INITIAL EACH INDIVIDUAL MEDICATION THAT YOU CONSENT TO BE GIVEN BY THE BACS CLINIC NURSE OR OFFICE PERSONNEL.

ANTIBIOTIC OINTMENT _____ COUGH DROPS _____ IBUPROFEN _____ TYLENOL _____

BENADRYL (LIQUID) _____ BENADRYL (CAPS) _____ BENADRYL GEL _____ TUMS _____

SIGNATURE OF PARENT OR GUARDIAN (REQUIRED)

DATE