LIFE CHRISTIAN ACADEMY - TACOMA, WA *whereLIFEhappens.org*

INTERNATIONAL STUDENT EMERGENCY CONSENT FORM / MEDICAL HISTORY

2016-2017 SCHOOL YEAR

OVER ⇨⇨⇨⇨

STUDENT INFORMATION

Name: _____ Gender: ☐ Male ☐ Female
First Middle Last

Address: _____
Street City Zip

Age: _____ Birth date: _____ / _____ / _____ Grade Entering: _____ Lives with: ☐ Both parents ☐ Father ☐ Mother ☐ Guardian ☐ Host ☐ Other
Month Day Year

Have you previously attended Life Christian? ☐ Yes ☐ No If yes, what year? _____

American Home Stay Family Name (Father & Mother): _____

Address (if different from student) _____ Home Phone: _____

_____ Work Phone: _____

E-Mail Address: _____ Cell/Pager #: _____

American Agency Representative Name: _____

Address: (if different from student)_____ Home Phone: _____

_____ Work Phone: _____

E-Mail Address: _____ Cell/Pager #: _____

Parents Name (Father & Mother): _____

Mailing Address: _____
Street City Country Postal Code

E-Mail Address: _____ Home Phone: _____ Cell Phone: _____

EMERGENCY INFORMATION - ALL INFORMATION MUST BE COMPLETED

_____
Local Doctor's Name Phone Number Preferred Emergency Care Facility

List names of people to be called if student is injured or becomes ill at school. Also list people who have permission to pick up your student after school and/or from the After-School Care Program. List in the order they are to be called.

Name	Primary Phone	Alternate Phone	Relationship to Student

☐ Allergies (meds or other) _____ ☐ Date of last tetanus booster _____

☐ Asthma _____ ☐ Other _____

Current medications being taken_____

CONSENT FOR HOSPITAL ADMISSION AND/OR PHYSICIAN'S CARE

Medical and Surgical Consent

I, the undersigned, hereby consent to all medical and surgical treatment by the attending physician and to the administration for performance of all examinations, administering of medicine, treatments, anesthetics, operations, x-rays, or other procedures which may be deemed necessary during the stay at this medical facility for _____ (student's name).

Financial Agreement

I hereby agree to accept responsibility for any financial indebtedness incurred during the hospitalization. I agree to pay for all necessary services at the current rate and in case of collection, pay reasonable attorney's fees and collection expenses.

I have read the above consent form and understand and agree to its content.

Parent Signature: _____ **Date:** _____

Home Stay Family Signature: _____ **Date:** _____

(over)

INTERNTIONAL STUDENT MEDICAL HISTORY

_____

Student Name | Date of Birth /Age | Today's Date

Date of last physical exam: _____ **Date of last dental check up:** _____
Doctor's Name: _____ **Dentist's Name:** _____
Doctor's Phone Number: _____ **Dentist's Phone Number:** _____

Does your child have now or previously had any of the following? If YES, explain briefly on line provided.

	YES	NO	
Allergies to medication	☐	☐	List:_____
Other allergies	☐	☐	List:_____ Epi-pen? __Yes __ No
Frequent headaches	☐	☐	_____
Convulsions/seizures	☐	☐	_____ Date of last seizure: _____
Hearing impairment	☐	☐	_____
Visual impairment	☐	☐	_____ Date of last eye exam: _____
Frequent ear infections	☐	☐	_____
Asthma	☐	☐	Inhaler? ☐ Yes ☐ No Triggers: _____
Hay fever	☐	☐	_____
Chronic bronchitis	☐	☐	_____
Sinus problems	☐	☐	_____
Heart abnormality	☐	☐	_____
Frequent stomach aches	☐	☐	_____
Frequent constipation	☐	☐	_____
Frequent diarrhea	☐	☐	_____
Kidney disease	☐	☐	_____
Blood disease	☐	☐	_____
Frequent nosebleeds	☐	☐	_____
Diabetes	☐	☐	Insulin pump? ☐ Yes ☐ No _____
Hypoglycemia	☐	☐	_____
Thyroid disease	☐	☐	_____
Arthritis	☐	☐	_____
Orthopedic injuries	☐	☐	_____
Skin problems	☐	☐	_____
ADD/ADHD (circle one)	☐	☐	Age when diagnosed _____ Medications? ☐ Yes ☐ No
Emotional problems	☐	☐	Please list: _____
			_____

Any other health problems or physical challenges which make participation difficult in classroom or physical activity?

_____

_____

List any medications being taken: _____

_____

Does your student have any special needs or problems that should be known to better care for and meet his/her needs?

_____

_____

Does your student use any assistive devices (e.g. glasses, hearing aides, braces, etc.)? Yes ☐ No ☐
If yes, please list: _____

Do you give permission for the school nurse to give Tylenol, Motrin, Claritin or Tums if it is necessary? Yes ☐ No ☐
Do you prefer a courtesy call prior to dispensing medication? Yes ☐ No ☐

Do you give permission for your student to use hand sanitizer? Yes ☐ No ☐

Girls only: Age when periods started _____

Any menstrual problems_____