EMERGENCY INFORMATION SHEET
CROSS OF GLORY LUTHERAN SCHOOL
WASHINGTON, MI

Student's Name____

Parent's Name____

Address____
Street City Zip Code

Home Phone:______________________ Cell Phone:_________________________ Pager:_______________________

Father's Place of Employment____________________________________Phone_______________________________

Mother's Place of Employment____________________________________Phone_______________________________

Alternate Person(s) to be notified:__________________________________Phone_______________________________

_________________________________Phone_______________________________

Physician (1st choice):____Phone________________________________

Physician (2nd choice):____Phone_______________________________

Preferred Hospital____Phone________________________________

Hospitalization Insurance Carrier:____

Numbers:____

Any known chronic illnesses: diabetes, rheumatic fever, allergies, etc.
____

Medications presently taken:
____

AUTHORIZATION TO CONSENT TO MEDICAL TREATMENT:
I authorize Cross of Glory Lutheran School authorities to consent to any x-ray, examination, anesthetic, medical or surgical diagnosis or treatment and hospital care, to be rendered to the minor under the general or special supervision and on the advise of any physician or surgeon licensed to practice, when the need for such treatment is immediate and when efforts to contact me (us) are unsuccessful.

Dated this__________________ day of_____________________ 20_________.

____
Signature of Parent or Guardian

Subscribed and sworn to before me, a Notary Public in and for_______________ County, Michigan,
this_________ day of _______________________, 20__________.

____
Notary Public

(ATTACH COPY OF PARENT/GUARDIAN DRIVER'S LICENSE TO BACK)

Special Medical Needs Agreement

In connection with the operations of **Cross of Glory Lutheran School (CoG),**

I, ____________________________________ ("Guardian"), as parent and/or legal guardian of

____________________________________ ("Child"), having the authority to execute this document, acknowledge and agree to the following:

1. **I have advised CoG that the above-listed Child has the following special medical needs:**
   - ○ Medical diagnosis of ____
   - ○ Allergies to ____
   - ○ Life-threatening reaction to this allergy is likely/probable.
   - ○ Moderate to severe (but not a life-threatening reaction to this allergy is likely/probable.
   - ○ Asthma
   - ○ Other:____
2. **As a result of this condition, multiple systems may appear, including:**
   - ○ Wheezing, panting, or other difficulty breathing
   - ○ Seizures
   - ○ Swelling (including restriction of airways)
   - ○ Discoloration of skin
3. **In connection with this condition, I have provided the following medications and/or medical equipment:** ____

   ____
4. **In the event that systems appear, I request the following course of action (check all that apply):**
   - ○ Locate one of the Child's guardians and advise him or her of the situation.
   - ○ Contact **emergency medical assistance by calling 911***
   - ○ Treat the symptoms in the following way (describe in detail, using space provided below, using additional pages if necessary): ____

   ____

   ____

   ____

   ____

   ____

   ____

***Note-If you indicate that a life-threatening reaction is likely, <u>we will call 911 if systems appear, whether or not the "contact emergency medical assistance" box has been checked.</u>**

5. **I have included on this form a complete statement of medications, procedures, or other interventions that are required in the event of an emergency; and I will provide all medication, inhalers, injectors, or other necessary items whenever the Child is participation in CoG activities.**
6. **I acknowledge and agree that while CoG, will attempt to take appropriate actions if such situations occur, CoG is not a medical facility and cannot be held liable for any resulting injury.**

For the Child to attend CoG activities, the Guardian acknowledges and accepts the risks of injury associated with the Child's pre-existing condition while participating in CoG activities. The Guardian also acknowledges and accepts the risks of injury or harm associated with intervention and/or treatment performed by CoG staff.

ACCORDINGLY, THE GUARDIAN AGREES ON BEHALF OF BOTH THE GUARDIAN AND THE CHILD, TO INDEMNIFY, DEFEND, AND HOLD HARMLESS CoG, AND ITS AGENTS, EMPLOYEES, VOLUNTEERS, AND OTHER REPRESENTATIVES FOR INJURY ARISING DIRECTILY OR INDIRECTLY OUT OF THE DESCRIBED MEDIAL NEEDS OF THE CHILD.

Provide any additional comments, clarification or direction below:

____

____

____

____

____

____

____

I agree that the above information is complete and accurate to the best of my knowledge, and I agree to the various terms of this Medical Conditions Form.

Signature: ____ **Date:** ____________________

Guardian of participant