Hillcrest Christian School
Medical Information Form

STUDENT'S NAME: _____ **GRADE**____**SOC. SEC. #:** _____

ADDRESS: _____**HOME PHONE:** _____

MOTHER'S NAME: _____**WORK #:** _____

FATHER'S NAME: _____**WORK #:** _____

OTHER - CELL/PAGER, ETC. _____

FAMILY DOCTOR'S NAME AND ADDRESS:

_____ **PHONE:** _____

INSURANCE COMPANY NAME AND ADDRESS:

_____

POLICY NUMBER: _____ **GROUP NUMBER:** _____

List any allergy conditions which at anytime have caused a medical crisis. Also, send us any medical information that you think is important. If a student is currently under a doctor's treatment, please send pertinent information. Please write any comments you may have below: (additional information may be included on back)

_____

_____

_____

_____

As a parent or guardian of _____**, I give permission to Hillcrest Christian School personnel (including, but not limited to, teacher, coach, principal, headmaster, etc.) to have my child treated by a physician in case of illness or in the event that emergency medical treatment is necessary from June 1, 2016 through May 31, 2017. I understand that every effort will be made to contact our family physician or me in case an emergency arises.**

Please include a copy, front and back, of your insurance card. In case an emergency arises, this information will facilitate speedy medical treatment.

Must be signed in the presence of a Notary Public

Parent / Guardian Signature:_____**Date:** _____

INVALID UNLESS NOTARIZED

SWORN TO AND SUBSCRIBED before me this the _____ **day of** _____**, 20**_____**.**

(Signature)_____ **(Title)**_____