



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, 2017 through May 31, 2018. 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) _____