



**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 _____, we give permission to Hillcrest Christian School personnel (including, but not limited to, teacher, coach dean/dean, headmaster, etc.) to have our child treated by a physician in case illness or in the event that emergency medical treatment is necessary from June 1, 2018 to May 31, 2019. We understand that every effort will be made to contact our family physician or us 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) _____