

CALVARY CHRISTIAN ACADEMY

A Ministry of Calvary Chapel Aurora
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ALLERGY & HEALTH INFORMATION • 2012/2013

If your child has any medication that needs to be left at school, it must be clearly labeled, prescribed by a doctor with dosage instructions included. Please provide the office with the medication in a reclosable plastic bag with your child's name along with the signed permission form by your physician.

Please mark below any allergies your child may have that the school needs to be aware of. Due to food allergies and other complications, we do not allow food to be shared with a child who has forgotten their lunch.

STUDENT INFORMATION					
STUDENT NAME (LAST, FIRST, MIDDLE) <i>FULL LEGAL NAME</i>			GRADE:		
GENDER <input type="radio"/> Male <input type="radio"/> Female			<input type="radio"/> Jr. Kindergarten		
			<input type="radio"/> Kindergarten	<input type="radio"/> Grade 1	<input type="radio"/> Grade 2
			<input type="radio"/> Grade 3	<input type="radio"/> Grade 4	<input type="radio"/> Grade 5
			<input type="radio"/> Grade 6	<input type="radio"/> Grade 7	<input type="radio"/> Grade 8
DATE OF BIRTH	AGE	HOME PHONE			
MY CHILD:					
<input type="checkbox"/> Does not have any known food allergies or health concerns.					
<input type="checkbox"/> Has food allergies. (please list)					

<input type="checkbox"/> This allergy is life-threatening and requires immediate medical attention. I understand it is my responsibility to provide the school with appropriate documentation and medicine(s) as listed above.					
<input type="checkbox"/> Has allergies other than food. (please list)					

<input type="checkbox"/> This allergy is life-threatening and requires immediate medical attention. I understand it is my responsibility to provide the school with appropriate documentation and medicine(s) as listed above.					
<input type="checkbox"/> Has health concerns. (please list)					

<input type="checkbox"/> Is on the following medications (dose, time given) on a regular basis. (please list)					

Student's Physician: _____			Student's Dentist: _____		
Physician Phone: _____			Dentist Phone: _____		
PARENT OR LEGAL GUARDIAN NAME (PLEASE PRINT)			PARENT OR LEGAL GUARDIAN NAME (PLEASE PRINT)		
PARENT OR LEGAL GUARDIAN SIGNATURE			PARENT OR LEGAL GUARDIAN SIGNATURE		
DATE	EMERGENCY PHONE NUMBER		DATE	EMERGENCY PHONE NUMBER	

