salembaptist
CHRISTIAN SCHOOL

429 S. Broad Street, Winston-Salem, NC 27101 (336)725-6113 Fax (336)725-8455

STUDENT MEDICAL EMERGENCY INFORMATION (PLEASE PRINT)

Student's Name: _____**Birthdate:**_____

Name of Parent or Guardian(s): _____

Address of Parent or Guardian: _____

City: _____ **State:** _____ **Zip:** _____

Emergency or cellular phone number(s):_____

Medical Information:

Medication(s) taken regularly and reason for medication(s):

List all allergies or allergic reactions:_____

List any chronic medical problems requiring a doctor's care_____

_____

Name of insurance provider:

Policy Number:_____Policy Holder:_____

Primary care physician and phone #_____

Hospital Preference: _____

Date of last tetanus booster or Tdap:_____

By my signature below, I confirm that all information listed above is complete and accurate, and I authorize SBCS employees to give emergency medical treatment to my child or transport them to a facility to be given emergency medical attention.

_____ _____

Signature of Parent or Guardian **Date**