

# HORIZON CHRISTIAN SCHOOLS

## 2009-2010 INTERNATIONAL STUDENT MEDICAL INFORMATION FORM

### PLEASE PRINT AND USE PEN

Student's Full Name: \_\_\_\_\_ Male/Female: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Grade: \_\_\_\_\_

Birth Father's Name: \_\_\_\_\_ Emergency Contact Phone Number: \_\_\_\_\_

E-mail: \_\_\_\_\_

Birth Mother's Name: \_\_\_\_\_ Emergency Contact Phone Number: \_\_\_\_\_

E-mail: \_\_\_\_\_

**Name two people to be contacted in case of an emergency and we are unable to contact a parent. Include relationship to the parent.**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

### HOST FAMILY - Can be completed by the office

Host Father's Name: \_\_\_\_\_ Emergency Contact Number: \_\_\_\_\_

Host Mother's Name: \_\_\_\_\_ Emergency Contact Number: \_\_\_\_\_

If needed, I authorize the Horizon Christian Schools office to administer the following medication as requested by my student, not to exceed the recommended dosage.

Yes  No Acetaminophen (Generic Tylenol)

Yes  No Ibuprofen (Generic Advil)

By signing this section you are authorizing the distribution of these over the counter medications for minor pain.

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### MEDICAL INFORMATION

Has your child ever received treatment for or been diagnosed with any ailment? (Heart, seizures, asthma, etc.?)  No  Yes

If yes, please explanation: \_\_\_\_\_

Does your child have any skin sensitivity to injected or oral medication?  No  Yes

If yes, please explanation: \_\_\_\_\_

Does your child have diabetes?  No  Yes  Type 1  Type 2  Unknown

Does your child have any other medical conditions that we need to be aware of?  No  Yes

If yes, please explanation: \_\_\_\_\_

Does your child take any daily medications at home?  No  Yes

If yes, please explanation: \_\_\_\_\_

Does your child need to take prescribed medications at school?  No  Yes

If yes, you must register this medication at the school office and complete an Administration or Prescribed Medication Form.  
(Please note that all medication must come in it's original packaging).

Does your child have immediate access to any medication? (inhaler, epi-pens, etc)  No  Yes

If Yes, please specify: \_\_\_\_\_

### PARENT SIGNATURE

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_