HERMISTON CHRISTIAN SCHOOL
MEDICAL HISTORY AND RELEASE FORM
2024-2025

Student Name _____ Age _____ Grade ___
First MI Last

Birthdate _____ Approx. height _____ Approx. Weight _____

Street Address: _____

City _____ St/Zip _____ Home Phone _____

Father _____ Phones: Cell _____ Work _____

Mother _____ Phones: Cell _____ Work _____

Emergency contact person when neither parent can be reached:

Name _____ Home Phone _____ Cell _____

Does your child have a history of:	**YES**	**NO**	**CURRENT MEDICATIONS (Prescription or OTC)**
Respiratory Problems (Asthma, Hayfever, Sinus, Bronchitis)			
Kidney Disease			
Diabetes/Hypoglycemia / Heart Disease / AIDS/HIV			
Epilepsy/Convulsions			
Nose bleeds			
Fainting spells			
Ear infections			
Bad headaches			
Hyperactivity/ADD/ADHD			
ALLERGIES: (Medications)			
ALLERGIES: (Bee stings, foods, etc.)			
Other:			
My child may be given if needed: Circle choice & check			
Tylenol Chewable Tylenol Advil Aleve			
Cold/Allergy medication Cough Syrup			
I do not wish my child to be given medication at any time.			

Date of last Tetanus Shot:

_____

Child's Doctor _____ Phone _____

Medical Insurance Provider _____ Policy No. _____

Parent/Guardian Statement: I authorize Hermiston Christian School staff to consent to medical treatment for my child when I cannot be contacted. I understand that every effort will be made to contact me before such action is taken. I also give consent for any medically authorized personnel to administer such treatment that he/she deems necessary in the event of an emergency. I assume full financial responsibility for emergency care given to my child, and will not, in any way, hold Hermiston Christian School liable.

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Parent/Guardian Signature Date