

Guardian Christian Academy
6851 Courthouse Road
Chesterfield, VA 23832
804-715-3210

HEALTH CONSENT AND WAIVER

Guardian Christian Academy
Expires August 31, 2019



Name _____ Birthday ____ / ____ / ____
 First Middle Initial Last (Nickname)

Male Female Grade during 2018/2019 _____

Parent/Guardian _____ Email _____

Phone (H) _____ Phone (W) _____ Phone (Cell) _____

Address _____ City _____ State _____ Zip _____

Second Parent/Guardian _____ Email _____

Phone (H) _____ Phone (W) _____ Phone (Cell) _____

Address _____ City _____ State _____ Zip _____

Emergency Contact _____

Phone (H) _____ Phone (W) _____ Phone (Cell) _____

Medical insurance carrier _____ Policy# _____ Group# _____

Carrier address _____ Name of insured person _____

Name of family physician _____ Phone _____

Name of dentist/orthodontist _____ Phone _____

Name of parent's/guardian's employer _____ Phone _____

Name of second parent's/guardian's employer _____ Phone _____

Health History (Check)

- | | | |
|---|--------------------------------------|---|
| <input type="checkbox"/> Frequent Ear Infection | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Bleeding Disorders |
| <input type="checkbox"/> Heart Defect/Disease | <input type="checkbox"/> Asthma | <input type="checkbox"/> Mononucleosis |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Frequent Migraines / Headaches | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Measles |

Allergies (Dates not needed)

- | | |
|--|--|
| <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Ivy Poisoning | <input type="checkbox"/> Insect Stings |
| <input type="checkbox"/> Drugs (Specify) _____ | |
| <input type="checkbox"/> Other _____ | |

Chronic or recurring illness or medical condition _____

Other health information that GCA should know (sign and date any additional pages) _____

Dietary restrictions due to health issues _____

Current medications (List prescription, OTC & herbal)

Medication name: _____ Dosage _____ How Often? _____ Reason for taking _____
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Blood type (if known) _____ Are all immunizations current? _____
(MMR-Date completed: _____; tetanus-Date: _____; hepatitis-Date: _____; Tdap-Date: _____)

Describe your student's swimming ability: Beginner _____ Intermediate _____ Advanced _____

As verified by the notarized signature on the reverse, in the event that I cannot be reached I give to any paramedic, medical doctor, or hospital my consent and authorization to render such aide, treatment or care to said student as, in the judgment of the doctor or hospital may be required, on an emergency basis, in the event said student should be injured or stricken ill while participating in an activity sponsored by the school.

(over)

