

CENTRAL CHRISTIAN ACADEMY
*1505 West Street * Southington, CT 06489*
(860) 621-6701

EMERGENCY MEDICAL INFORMATION

1. Student's Name _____ Home Phone #:(_____)_____
2. Date of Birth _____ Social Security # _____
3. Address _____
4. Please list any allergies your child has had: _____
5. Please list any diseases your child has had: _____
6. Please check if your child is subject to: Asthma Earache Hay Fever Bronchitis Other
7. Please list any medications your child takes regularly: _____
8. In case of an emergency requiring medical care outside of the school, please indicate the sequence in which you would like us to contact you.
 Contact father: Phone # _____
 Contact mother: Phone # _____
 Contact personal physician: Name _____ Phone #:(_____)_____
 Take child to nearest hospital
 Take child to _____ Hospital. City: _____
 Other Procedure: _____
9. In case of surgical emergency, I hereby give permission to the physician selected by the Central Christian Academy Administrator to hospitalize, secure proper treatment, and order injection, anesthesia or surgery for my child.

Parent's Signatures:

Father

Mother

Date: _____