Makua Lani Christian School
2009-2010 Student Emergency Information

STUDENT INFORMATION

Name:______________________________ Grade:________ Birth date:__________ Cell #:__________

Name:______________________________ Grade:________ Birth date:__________ Cell #:__________

Church now Attending:______________________ **Pastor:**______________________

Attending Sunday School? _______ **yes** _______ **no** **Attending Youth Group** ______ **yes** ______ **no**

PARENT INFORMATION

Father/Legal Guardian:______________________________

Mailing Address______________________ Home phone:__________

City, State, Zip______________________ Work phone:__________

E-mail address:______________________ Cell Phone/Pager:__________

Mother/Legal Guardian:______________________________

Mailing Address______________________ Home phone:__________

City, State, Zip______________________ Work Phone:__________

E-mail address:______________________ Cell Phone/Pager:__________

MEDICAL INFORMATION

Insurance Coverage:______________________ Policy Number:__________

Medical conditions, allergies, medications that we should be aware of?__________________

Doctor's Name:______________________ Phone #:__________

EMERGENCY CONTACTS

If Makua Lani staff is unable to contact above parents, I authorize the following people to be called in an emergency:

1. *Name:*__________________ *Relationship to student:*__________________
   Work Ph. #__________________ Home Ph. #__________________

2. Name:__________________ Relationship to student:__________________
   Work Ph. #__________________ Home Ph. #__________________

3. Name:__________________ Relationship to student:__________________
   Work Ph. #__________________ Home Ph. #__________________

I hereby agree that if Makua Lani staff is unable to contact me or one of the persons listed as emergency contact, I hereby consent that if my son/daughter exhibits signs of illness or injury, that at the discretion of Makua Lani administration, my child may be taken to the nearest *medical facility and be given any examination/treatment that is deemed necessary by the personnel of the medical facility.*

DISPENSATION OF MEDICATION

The school office has aspirin substitutes (ibuprofen/acetaminophen) available to students upon request for headaches, aches/pains. A maximum of 2 caplets per day per student will be allowed. Please indicate your preference below.

_______My child (ren) can determine for him/herself the need to take aspirin substitutes dispensed by the school

_______My child (ren) may NOT receive aspirin substitutes from the school.

Parent / Guardian Signature:______________________ **Date**__________

BACK-

Video Permission Form

Please check below which of the following movie ratings, if any, you give permission for your student to view during the school year of 2009-2010.

_______ **G** Rated

_______ **PG** Rated

_______ **PG 13** Rated

_______ I **do not** want my student to view any videos without contacting me, the parent, first.

Parent Signature	**Telephone No.**	**Date**