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MEDICAL INFORMATION FORM

It is vitally important for the safety and well being of your child that we have the information requested on this form in case of an emergency. Please fill out this form completely for each child. Please notify the school of any changes when available.

Student's Name: _____ Date of Birth: _____

Parent /Guardian: _____

Home Phone #: _____

Cell Phone #: _____

Work #: _____

Parent /Guardian: _____

Home Phone #: _____

Cell Phone #: _____

Work #: _____

Three local relatives/friend who can be reached in an emergency:

1.

Name: _____ Relationship: _____

Phone #: _____

2.

Name: _____ Relationship: _____

Phone #: _____

3.

Name: _____ Relationship: _____

Phone #: _____

Student's Pediatrician: _____ Phone #: _____

Student's Dentist: _____ Phone #: _____

Preferred Hospital:

MEDICAL HEALTH CARE

Insurance Company: _____

Group #: _____

Policy #: _____

Phone #: _____

SSN #: _____

Is your child on medication? [YES] [NO]

If yes, what is the name? _____

How often is it administered? _____

ALLERGY

Is your child allergic to anything? If yes, Explain.

_____.

Describe all medical conditions that the school needs to be aware of and any special measures the school may need to take to facilitate your child (i.e., asthma, ADHD, ear infection, hearing problems, and vision. Only a limited number of students with special needs may be admitted in each class. If the school deems that the class cannot include an additional student with learning needs without compromising the instruction of the entire class, it reserves the right to deny enrollment.

EMERGENCY INSTRUCTION

If a medical emergency arises concerning your child and the school cannot reach you, do you give your consent to the school to notify a local hospital of the emergency?

If no, what are your instructions? Explain

_____.

Parent Signature: _____

Print your name: _____

Date: _____