

# Medical Form for Re-Enrollment

Name of Student \_\_\_\_\_ Date of Birth \_\_\_\_\_ Male / Female  
 Primary Care Physician \_\_\_\_\_ Telephone \_\_\_\_\_  
 Dentist \_\_\_\_\_ Telephone \_\_\_\_\_

### MEDICAL CONSENT: PAYMENT OF EXPENSES

The Parent grants permission to the School and its employees and agents to take the Student to a licensed physician for medical treatment, emergency surgery, or hospitalization if the Student becomes ill or sustains an injury or otherwise requires medical treatment or attention and the School cannot contact the Parent. The Parent gives consent to any licensed physician to administer drugs or medicine or to perform such medical procedures as that physician determines necessary for the relief of pain and to preserve the Student's life or health.

The Parent agrees to assume the responsibility for all medical, transportation, rescue and other related expenses incurred on behalf of the Student.

\_\_\_\_\_  
 Signature of Parent or Legal Guardian      Date      Signature of Parent or Legal Guardian      Date

### LIFE THREATENING MEDICAL CONDITIONS: (CHECK ALL THAT APPLY)

Please explain any **YES** answers

- |                             |                              |   |  |
|-----------------------------|------------------------------|---|--|
| <input type="checkbox"/> No | <input type="checkbox"/> Yes | 1. Asthma   | _____  |
| <input type="checkbox"/> No | <input type="checkbox"/> Yes | 2. Bee/insect allergy (needs special care)                    | _____  |
| <input type="checkbox"/> No | <input type="checkbox"/> Yes | 3. Severe allergies – affecting school                        | _____  |
| <input type="checkbox"/> No | <input type="checkbox"/> Yes | 4. Diabetes   | _____  |
| <input type="checkbox"/> No | <input type="checkbox"/> Yes | 5. Blood disorder   | _____  |
| <input type="checkbox"/> No | <input type="checkbox"/> Yes | 6. Orthopedic condition                                       | _____  |
| <input type="checkbox"/> No | <input type="checkbox"/> Yes | 7. Chronic condition/disability                               | _____  |
| <input type="checkbox"/> No | <input type="checkbox"/> Yes | 8. Serious illness/injury/surgery                             | _____ Date _____   |
| <input type="checkbox"/> No | <input type="checkbox"/> Yes | 9. Frequent ear infections                                    | _____  |
| <input type="checkbox"/> No | <input type="checkbox"/> Yes | 10. Hearing concerns  | _____  |
| <input type="checkbox"/> No | <input type="checkbox"/> Yes | 11. Vision concerns   | <input type="checkbox"/> Glasses <input type="checkbox"/> Contacts Other _____ |
| <input type="checkbox"/> No | <input type="checkbox"/> Yes | 12. Speech difficulties/hoarseness                            | _____  |
| <input type="checkbox"/> No | <input type="checkbox"/> Yes | 13. Severe headaches  | _____  |
| <input type="checkbox"/> No | <input type="checkbox"/> Yes | 14. Seizures  | _____  |
| <input type="checkbox"/> No | <input type="checkbox"/> Yes | 15. Neurological condition                                    | _____  |
| <input type="checkbox"/> No | <input type="checkbox"/> Yes | 16. ADD/ADHD (diagnosed by whom)                              | _____  |
| <input type="checkbox"/> No | <input type="checkbox"/> Yes | 17. Heart condition   | _____  |
| <input type="checkbox"/> No | <input type="checkbox"/> Yes | 18. Concerns with early development                           | _____  |
| <input type="checkbox"/> No | <input type="checkbox"/> Yes | 19. Other health concerns                                     | _____  |
| <input type="checkbox"/> No | <input type="checkbox"/> Yes | 20. Any condition which limits participation in regular P.E.? | _____  |

Limits are \_\_\_\_\_

WA state law requires a medication/treatment order from a Health Care Provider if your child's health condition will put your child in danger of death during the school day. Written orders must be received by the School Nurse before your child can attend school. A form is available from the office and on-line at [www.libertychristian.net](http://www.libertychristian.net) or in Parents Web.

### Medication Information (medications taken at home)

Name of Medication (s) \_\_\_\_\_

WA state law requires an Authorization for Administration of Medication at school to be authorized by a Licensed Health Professional (LHP). This form is available from the office and on-line at [www.libertychristian.net](http://www.libertychristian.net) or in Parents Web.

*Liberty Christian School does not discriminate on the basis of race, color, national or ethnic origin in the administration of its admission policies, educational policies, athletic and other school-administered programs.*