



## Grace Christian School Of Armstrong County

*"Growing Christ-like Students"*

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### EMERGENCY MEDICAL INFORMATION

(Please Print)

Student's Name \_\_\_\_\_ Birth \_\_\_\_\_ Grade \_\_\_\_\_  
(Last) (First)

Address \_\_\_\_\_

In case of an emergency, where can parents usually be reached if not at home?

Mother: Address \_\_\_\_\_ Phone # \_\_\_\_\_

Father: Address \_\_\_\_\_ Phone # \_\_\_\_\_

List two neighbors or relatives who live nearby whom you agree to allow to assume temporary care of your child if you cannot be reached at home.

(Parents should make arrangements with the people named below.)

Name: \_\_\_\_\_ Phone # \_\_\_\_\_

Address: \_\_\_\_\_

Name: \_\_\_\_\_ Phone# \_\_\_\_\_

Address \_\_\_\_\_

Does your child have any medical problem which you wish to call to the attention of the school?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please elaborate on reverse side with as much detail as possible.

In case of accident or serious illness, I request the school to contact me. If the school is unable to reach me at the neighbor or relatives listed above, or the situation demands immediate medical attention, I give permission to school personnel to administer first aid. I also authorize the school to arrange to have my child taken to the emergency room of the nearest hospital by ambulance. I authorize Emergency medical Personnel to perform necessary care for my child. Once admitted to the Emergency Room, I give permission for necessary medical/surgical care of my child.

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

Remarks:

Local Family Physician's Name: \_\_\_\_\_

Address \_\_\_\_\_

Office Phone # \_\_\_\_\_