New Harvest Christian School

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2022-2023 Student EMERGENCY Information

1. Name: ____ **M / F**
Last First Middle — Circle Gender

____/____/____ Birth date ____________ Name child prefers to be called ____________ Grade Entering

2. Name: ____ **M / F**
Last First Middle — Circle Gender

____/____/____ Birth date ____________ Name child prefers to be called ____________ Grade Entering

3. Name: ____ **M / F**
Last First Middle — Circle Gender

____/____/____ Birth date ____________ Name child prefers to be called ____________ Grade in Entering

4. Name: ____ **M / F**
Last First Middle — Circle Gender

____/____/____ Birth date ____________ Name child prefers to be called ____________ Grade in Entering

5. Name: ____ **M / F**
Last First Middle — Circle Gender

____/____/____ Birth date ____________ Name child prefers to be called ____________ Grade in Entering

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____________ Mother's Name (____) ________ Home Phone (____) ________ Work Phone (____) ________ Cell Phone

____________ Mother's Home Address ________ City CA ________ Zip Code

____________ Father's Name (____) ________ Home Phone (____) ________ Work Phone (____) ________ Cell Phone

____________ Father's Home Address if different from Mother's ________ City CA ________ Zip Code

Mother's Marital Status: ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Single
Father's Marital Status: ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Single
Child(ren) live(s) with: ☐ Both parents ☐ Mother ☐ Father ☐ Shared Custody ☐ Guardian(s)
If the child is not living with **both** parents, who has legal custody? ______________________

EMERGENCY INFORMATION:

Alternate Emergency Contact Persons Authorized to Pick Up Child(ren): Please list your emergency numbers in the sequence you want them called. Use extra paper for additional authorized contact/pick up persons if needed.

1. ____________ Name ____________ Relationship to child(ren) (____) ________ Home Phone (____) ________ Work Phone (____) ________ Cell Phone

2. ____________ Name ____________ Relationship to child(ren) (____) ________ Home Phone (____) ________ Work Phone (____) ________ Cell Phone

3. ____________ Name ____________ Relationship to child(ren) (____) ________ Home Phone (____) ________ Work Phone (____) ________ Cell Phone

MEDICAL AND DENTAL INSURANCE INFORMATION:

____ (________) ________________
Doctor's Name — Area Code — Phone Number

Address: ____ Zip: ________________

____ (________) ________________
Dentist's Name — Area Code — Phone Number

Address: ____ Zip: ________________

_______________________________________ (_______)______________ ______________________
Insurance Provider No. 1 — Area Code — Phone Number — Policy Number

Address: ____ Zip: ________________

_______________________________________ (_______)______________ ______________________
Insurance Provider No. 2 — Area Code — Phone Number — Policy Number

Address: ____ Zip: ________________

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If your child(ren) has/have known allergies or chronic health problems, please list the child's/children's name(s) medical problem and medications taken daily.

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CONSENT FOR MEDICAL TREATMENT IN CASE OF EMERGENCY:

I understand that all reasonable safety precautions will be taken by the school administration, and that the possibility of an unforeseen hazard does exist. I agree not to hold New Harvest Christian School, Faith Community Church, its leaders, employees and volunteer staff liable for damages, losses, diseases, or injuries incurred by the minor(s) listed on this form.

As the parent or legal guardian I hereby give authorization to NHCS to obtain emergency medical treatment from a duly licensed medical care provider for my child in the event of illness or injury. I consent to any x-ray, anesthetic, medical, surgical, or dental diagnosis or treatment that may be deemed necessary for my minor child. This care may be given under whatever conditions deemed necessary to preserve the life, limb or wellbeing of my dependent.

I understand that all efforts will be made to contact me prior to treatment. In the event I cannot be reached in an emergency, I give permission to the administrators to make the decisions necessary for treatment. I further understand that the doctors, dentists and other providers attending to my child will take all reasonable safety precautions during their care.

Further, as parent or legal guardian, I am responsible for the health care decisions for my minor child and agree that my insurance plan is the primary plan to pay for the dental, medical, or hospital care or treatment that is given to my child. Any policy of the school will be used as the secondary coverage.

Date: ______________________________ Date: ______________________________

______________________________ ______________________________
Signature of Parent or Guardian — Signature of Parent or Guardian

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NOTE: There are separate authorization forms (in the school office) that must be completed and signed by you if your child(ren) needs prescribed or non-prescribed medication during school hours. Such medication will be kept in the school office and administered by office personnel for the safety of your child(ren).