Bethel Baptist Christian Academy
200 Hunt Road, Jamestown, NY
Website: bbcajamestown.weebly.com
Phone 716-484-7420
Fax 716-484-0087
Email:bbcaoffice03@gmail.com

Emergency Medical Treatment Form

Students Name _____Date of Birth_____Grade_____

Part 1 – New Students

1. All new students are required to provide official records of immunizations to BBCA prior to entering school. Students will not be able to attend until proof of immunizations is submitted. Official records would be either immunization records from a previous school or a copy from a doctor's office/clinic.
2. All new students must provide documentation of a current physical within the past 12 months.

Part 2 – All students

1. Please note any information that would be helpful to an attending physician in a medical emergency.
   - My child wears contacts _____yes _____no
   - My child has the following allergies: _____
   - My child has this special condition_____
   - My child takes the following prescription drugs _____
   - Other relevant and appropriate information_____
   - Date of last tetanus shot (month/year)_____/_____

2. Family Physicians name_____ Phone_____
3. Insurance _____ I.D. #_____
4. Permission is granted for the student named above to travel to and from with BBCA athletic teams or any school sponsored function by bus (or car if necessary).
5. In case of emergency we **do** _____**do not**_____ give permission for medical treatment at the nearest medical facility if deemed advisable by the person in charge. This permission is also granted for home games when we cannot be contacted.
6. We will not hold BBCA responsible for accident/injury liability, either during school hours or during extra-curricular activities including athletic contests, class trips, and class socials.

EMERGENCY PHONE NUMBERS

Home (___) ____-_____ Father's work (____) ____-_____/ Cell #_____
Mother's work (____) ____-_____/Cell # (____) ____-_____
Other Emergency Contact (____) ____-_____
Name and Relationship to Student_____
Other Emergency Contact (____) ____-_____
Name and Relationship to Student_____

We agree that the above information may be shared with appropriate faculty/staff or health care providers if deemed advisable by the person in charge.

Signatures of both Parents (or guardians) are required. Please print and sign.

_____ Date_____ _____ Date _____

Mother Father

BETHEL BAPTIST CHRISTIAN ACADEMY **STUDENT HEALTH HISTORY UPDATE**

Name:	DOB: Age: Grade:	Gender: ☐ M ☐ F
Parent/Guardian: (person completing this form)	Home Phone: Cell Phone:	Date:

Has your child ever:	**YES**	**NO**	**If Yes, please explain and include date:**
Had an ongoing medical condition	☐	☐	
Seen a medical specialist	☐	☐	
Had allergies:	☐	☐	☐food ☐environmental ☐insect ☐medication ☐other
Been hospitalization	☐	☐	
Had an operation	☐	☐	
Had an injury requiring an Emergency Room visit	☐	☐	
Missed 5 days of school in a row due to illness/injury	☐	☐	
Had a bone/muscle injury	☐	☐	
Passed out, had a concussion or serious head injury	☐	☐	
Had a convulsion/seizure	☐	☐	
Had a vision problem or condition	☐	☐	☐ glasses ☐ contacts
Had a hearing problem or condition	☐	☐	☐ hearing aid ☐ cochlear implant
Worn dental bridge, braces or mouthpiece	☐	☐	
Have any family members under the age of 50 ever:	**YES**	**NO**	**If Yes, please specify:**
Had a heart attack	☐	☐	
Had other serious health problems	☐	☐	

CHECK ALL THAT APPLY TO YOUR CHILD:

☐ ADHD
☐ Asthma/trouble breathing
☐ Autism/Asperger
☐ Dental Injuries
☐ Diabetes
☐ Ear Infections
☐ GI Conditions (ulcer, reflux, IBS)
☐ Headaches/migraines
☐ Heart Conditions
☐ High Blood Pressure
☐ Mental Health Condition (depression, eating disorder, anxiety, OCD, ODD, etc.)
☐ Scoliosis
☐ Single Organ (kidney, testicle)
☐ Skin Conditions
☐ Speech Condition
☐ Urinary Condition

CURRENT MEDICATIONS	**YES**	**NO**	**Please list name, dose, time(s)**
Given at school	☐	☐	
Taken at home	☐	☐	
ASSISTIVE EQUIPMENT	**YES**	**NO**	**Please check all that apply**
During or outside of school	☐	☐	☐crutches ☐walker ☐wheelchair ☐other:
TREATMENTS	**YES**	**NO**	
During or outside of school	☐	☐	☐insulin/blood glucose monitoring ☐inhaler/nebulizer/peak flow monitoring ☐special diet

Is there any condition that would prevent your child from participating in physical education or sports?
☐No ☐Yes:_____

Please list any additional concerns: (Use separate sheet if necessary)_____
Are there any changes to the Students health since last year? (Use separate sheet if necessary)_____

Parent/Guardian
Signature:_____ Date:_____

Bethel Baptist Christian Academy

Medical Information Release Form

This form allows the providers designated below to share medical information concerning your child with the school district. This information will be used to allow health care collaboration to maintain student safety, provide care, or create/modify programming. Please sign and give this form to your health care provider and one to your school nurse.

Authorization for use or disclosure of protected health information.

I_____ authorize my child's health care provider listed below to share information of my child, (full name)_____, date of birth_____, with the school nurse and teachers/staff involved with the student.

List Health Care Providers (physician, dentist, mental health care providers)

Name_____Phone_____

Name_____Phone_____

The health care provider may disclose the following protected health information

- Immunizations
- Health appraisals
- Past/current medical conditions and impact on attendance and or care at school or with school programming.
- Other_____

The protected health information may be used, disclosed or received for the following purposes:

- To develop care or therapy plans for routine and emergent school management.
- To assess the impact of the medical conditions on school programming and/or attendance in order to design appropriate educational programs.
- To share school observation/concerns surrounding behavior
- To assess a medical basis for modification of transportation and/or home tutoring.
- Medication delivery or therapy prescriptions
- Other_____

This authorization is valid for the academic school year 20____/20____ Grade_____

I acknowledge that I have the right to revoke this authorization at any time by sending written notification to the health care provider and the school health office. I understand that the revocation of this authorization is not effective if the health care provider or district has used the authorization for disclosure of protected health information before receiving my written revocation notice. I understand that any protected health information disclosed as a result of this authorization, and not covered by state and federal privacy laws and regulations, may be subject to re-disclosure and may no longer be protected by federal and state law.

Signature of patient (over 18), parent, or guardian_____

Date_____

Relationship _____

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PARENT AND PRESCRIBER'S AUTHORIZATION FOR
ADMINISTRATION OF MEDICATION AT BETHEL BAPTIST CHRISTIAN ACADEMY

Child's Name_____D.O.B._____Grade_____

To be completed by the licensed health care provider:

I request that my patient, as listed above, receive the following ***PRESCIPTION MEDICATIONS or OVER-THE-COUNTER MEDICATIONS*** during school hours (and extra-curricular activities):

DIAGNOSIS_____

MEDICATION	DOSAGE	FREQUENCY	ROUTE	TIME	REASON
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
Acetaminophen	_____	_____	_____	_____	_____
Ibuprofen	_____	_____	_____	_____	_____
Mentholyptus lozenges	_____	_____	_____	_____	_____

Possible side effects and adverse reactions (if any):_____

Student is designated independently self-carry, self-directed' Yes___ No____

Supervised self-directed Yes____ No_____

Nurse Dependent Yes____ No____

I request that my above listed patient may receive the following OVER-THE-COUNTER MEDICATIONS (which will be provided by BBCA) during school hours and extra-curricular activities on an as needed basis. Please **CIRCLE** all that apply.

Unscented Hand lotion Sterile Saline Eye Drops Vaseline Calamine Peroxide

Name of Licensed Prescriber and Title (please print):_____

Prescriber's Signature_____Date_____

Parents Signature_____Date_____