



Shadowing Emergency Medical Form

 Student's Last Name (please print) First Middle Birth date Age Grade Home Phone

 Address City State Zip

 Father/Guardian Daytime Phone Cell Phone

 Mother/Guardian Daytime Phone Cell Phone

Is your child allergic to any medication? _____ If yes, please specify: _____

Is he/she allergic to bee stings? _____ If yes, what action should be taken? _____

Primary Care Physician _____ Phone _____

Persons to whom my child may be released in the event of illness or emergency and I cannot be reached:

Name	Home Phone/Cell Phone/Work Phone	Relationship

Agreement and Release from Liability

Except for damages arising out of the willful negligence of Valley Christian Schools, I hereby agree to indemnify and hold harmless Valley Christian Schools, its officers, directors, and employees, and any other organization co-sponsoring the program, from and against any and all liability or injuries which I or my child may suffer arising out of or in any way connected with my or my child's participation in this program. In case of emergency, arising during or in connection with any activity, I authorize any person in charge of the activity to consent to emergency expense, at my expense. I understand that Valley Christian Schools is not obligated to carry any insurance to cover medical and / or dental treatment for me or my child. I agree to pay any damages or expenses incurred by Valley Christian Schools due to my or my child's negligence or disregard of the rules of the program.

Insurance Co. which covers my child: _____

Policy # _____ Student ID # _____

Hospital Preference _____

Date _____ Signature of Parent/Guardian _____