EMERGENCY/MEDICAL INFORMATION

HAWAIIAN MISSION ACADEMY
1438 Pensacola St., Honolulu, HI 06822
808-536-2207, FAX 808-524-3294
www.hawaiianmissionacademy.org

STUDENT INFORMATION IN CASE OF EMERGENCY

Student Name:		Dorm?	**Yes** **No**
Date of Birth		Social Security/ Passport #:	
Preferred Doctor:		Phone Number:	
Preferred Hospital:		Phone Number:	

PARENT FIRST: In case of emergency we will try to contact the parent(s) first. Please list two alternate people who can assume responsibility for this student if the parent cannot be reached.

1st Alternate:		Phone:	
2nd Alternate		Phone:	
Date of Last Physical Exam:		Blood Type:	

List ANY allergies (food, drug, insect, etc.) or other health problems (asthma, disability, chronic disease, limited vision or hearing, etc.)

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Does this student need medication? ____________ If yes, list: ______________________________

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NOTE: The school cannot administer ANY medications (even aspirin or cough drops) unless we receive the following:
1. the medication in its original container **2.** clear instructions for administering
3. a note signed by the student's parent **AND** the student's physician authorizing Hawaiian Mission Academy to administer the medication.

CONTINUING CONSENT TO TREATMENT

I hereby grant Hawaiian Mission Academy permission to seek medical attention for the above named student in the event of an emergency, if the school cannot contact me. I further consent to medical or surgical treatment by any licensed physician and/or hospital. I also permit the administering of necessary anesthetics, medical treatments, test, transfusions, injections or drugs and the performance of whatever operation may be deemed necessary or advisable. I am the guarantor for any/all emergency/Medical treatment my student receives. Above is the information for my insurance OR in the event I do not have insurance, any bills for treatment can be sent to me at the address listed below if there are charges beyond what the school's accident insurance covers. **This Continuing Consent to Treat is valid for all camping and field trip permission slips I sign throughout the 2015-2016 Academic year. I will contact the school if my information changes.**

______________________________ ______________________________ ____________
Parent Signature: Printed Name Date

Work Phone		Home Phone:		Cell Phone:	

Insurance Carrier:		Employer:	
Group number:		ID Number:	

PICK-UP AND VISITATION

Declare any restraining orders or prohibitions against visitation or pick-up of this student. (Use back of this sheet if needed.)