

**CLC Emergency Medical Information Form 2024-2025**

Student: Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Birth Date \_\_\_\_\_

**PHYSICIAN INFORMATION**

Child's Physician: \_\_\_\_\_ Physician's Phone Number: \_\_\_\_\_

**EMERGENCY MEDICAL INFORMATION**Insurance Company: \_\_\_\_\_ Name of Insured: \_\_\_\_\_  
ID#: \_\_\_\_\_ Group #: \_\_\_\_\_ Telephone: \_\_\_\_\_**HEALTH HISTORY** (Please answer all questions completely.)Does your child have any ongoing or chronic illness (such as asthma)? ☐ Yes ☐ No

If so, what?: \_\_\_\_\_

Does your child have any allergies (medicine, food, insects, animals, etc.)? ☐ Yes ☐ No

If so, please list and indicate severity. \_\_\_\_\_

Has your child had any previous serious illnesses and/or injuries? ☐ Yes ☐ No

If so, please list occurrence and date: \_\_\_\_\_

Has your child been hospitalized within the past 12 months? ☐ Yes ☐ No

If so, please list occurrence and date: \_\_\_\_\_

Is your child currently taking any prescription medication? ☐ Yes ☐ No

If yes, please list: \_\_\_\_\_

Will you be providing CLC with medication to be used in case of an emergency? ☐ \*Yes ☐ No

(\*If yes, additional forms must be obtained, completed, and returned to the CLC Office prior to the first day of school.)

**I/We give permission for my/our child to have first-aid products administered when deemed necessary. *Please indicate with a check mark any/all items your child may receive.***

- ☐ Neosporin antibiotic ointment (or equivalent) for abrasions
- ☐ Benadryl ointment or spray (or equivalent) for itching
- ☐ Calamine lotion (or equivalent) for itching
- ☐ Oral Benadryl (or generic equivalent) in case of an extreme allergic reaction
- ☐ Sterile eye wash

**I AUTHORIZE A REPRESENTATIVE OF PRESTONWOOD BAPTIST CHURCH CHRISTIAN LEARNING CENTER TO GIVE CONSENT FOR ANY AND ALL NECESSARY MEDICAL CARE FOR MY CHILD WHILE SAID CHILD IS IN THE CUSTODY OF PRESTONWOOD BAPTIST CHURCH CHRISTIAN LEARNING CENTER.**\_\_\_\_\_  
Parent or Legal Guardian Signature\_\_\_\_\_  
Date

(See backside of this form.)

Student Name: \_\_\_\_\_

**I/WE, THE UNDERSIGNED, AM/ARE THE PARENT(S) AND/OR LEGAL GUARDIAN(S) OF THE ABOVE NAMED CHILD (THE “STUDENT”), AND HEREBY AGREE TO FULLY RELEASE, INDEMINIFY, AND HOLD HARMLESS PRESTONWOOD BAPTIST CHURCH, INC., ITS AFFILIATES OR SUBSIDIARIES INCLUDING, BUT NOT LIMITED TO, CHRISTIAN LEARNING CENTER, AND ITS OFFICERS, DIRECTORS, EMPLOYEES, AGENTS, VOLUNTEERS, MEMBERS, AND REPRESENTATIVES (COLLECTIVELY, “PRESTONWOOD CLC”), FROM ANY AND ALL SUITS, DEMANDS, CLAIMS, OR CAUSES OF ACTION, KNOWN OR UNKNOWN, THAT WE POSSESS NOW OR IN THE FUTURE, AND/OR COSTS, DAMAGES, OR EXPENSES, INCLUDING, BUT NOT LIMITED TO, ATTORNEYS’ FEES, COURT COSTS, AND LEGAL EXPENSES, OF WHATSOEVER KIND AND NATURE, IMPOSED UPON, INCURRED BY, OR ASSERTED AGAINST PRESTONWOOD CLC RELATED TO OR ARISING FROM THE SERVICES PROVIDED BY PRESTONWOOD CLC, INCLUDING, BUT NOT LIMITED TO, CLAIMS FOR PROPERTY DAMAGE, BODILY INJURY OR HARM, OR DEATH, UNLESS SUCH DAMAGE, INJURY, HARM, OR DEATH RESULTS FROM THE GROSS NEGLIGENCE OR INTENTIONAL MISCONDUCT OF PRESTONWOOD CLC. I/WE AGREE TO THIS RELEASE, INDEMNIFICATION, AND HOLD HARLMLESS PROVISION FOR AND ON BEHALF OF THE STUDENT, MY SPOUSE (IF ANY), MY/OUR CHILD’S MEDICAL PROVIDERS, AND MY/OUR INSURERS.**

In the event that I cannot be reached to make arrangements for emergency medical attention and the Student suffers an accident or sudden illness, I authorize Prestonwood CLC to arrange for the Student to receive medical attention from the physician listed in the Student’s Application or, if reasonably necessary, any other licensed physician or medical professional, and I give my consent for any and all treatment for the Student (including, but not limited to, X-ray exam, anesthetic, medical, surgical or dental diagnosis and treatment, and/or hospital care) while in the care and/or under the direction of the physician or medical professional. Moreover, in such an event, I authorize a representative of Prestonwood CLC to transport the Student to an available medical facility or emergency facility for such medical treatment.

I/We shall be liable and agree to pay all costs and expenses (medical and transportation) incurred in connection with such medical and/or dental services rendered to the Student.

I understand and acknowledge that it is my responsibility to notify Prestonwood CLC of any changes in the Student’s medical condition, guardianship, emergency contacts, address or phone number, **in writing**, by providing such notice to the CLC Office.

I give permission for the information on this form to be shared with the Student’s teacher(s) at CLC, unless I otherwise notify Prestonwood CLC **in writing** by providing such notice to the CLC Office.

\_\_\_\_\_  
**Signature of Parent/Guardian signed in presence of notary**

\_\_\_\_\_  
**Date**

**State of Texas**

**County of Denton**

**Before me, \_\_\_\_\_, a Notary Public, on this day personally appeared**

**\_\_\_\_\_, known to me (or proved to me on the oath of \_\_\_\_\_) to be the person whose name is subscribed to the foregoing instrument and acknowledged to me that he/she executed the same for the purposes and consideration therein expressed.**

**Given under my hand and seal of office this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.**

**Notary Public in and for the State of Texas: \_\_\_\_\_**

**My commission expires: \_\_\_\_\_**