RIVERSIDE CHRISTIAN SCHOOL
360.835.5600 | 463 N. Shepherd Rd, Washougal, WA, 98671 | Riversidesch.com

Consent to Treat & Health Information

This form is in effect as long as the said student is enrolled at Riverside Christian School or until such time the parents or guardian request, in writing, that it be terminated.

Last:	First:	Middle:	
Birthdate: mm/dd/yy	Gender: ❑ Male ❑ Female	Grade:	Blood Type:

Parent/Legal Guardian:	Relationship:	
Home: ( )	Cell: ( )	Work: ( )
Parent/Legal Guardian:	Relationship:	
Home: ( )	Cell: ( )	Work: ( )
Emergency Contact (non-parent, if parent is unavailable):	Relationship:	
Home: ( )	Cell: ( )	Work: ( )

Does your child have medical insurance coverage? ❑ Yes ❑ No	Provider:	
Physician's Name:	Clinic & Address:	Office Phone: ( )

Does your child have dental insurance coverage? ❑ Yes ❑ No	Provider	
Dentist's Name:	Clinic & Address:	Office Phone: ( )

I authorize and consent to medical, surgical, and hospital care, treatment and procedures to be performed for my child listed above, by a licensed physician or hospital when, in the sole discretion of the attending physician, such care, treatment, and procedure are immediately necessary or advisable in the interest of my child's health and well-being, after the school has made every effort to contact me.

I understand that I will assume full responsibility for payment of any transport or emergency medical services rendered.

It is further understood that this consent is given in advance of any specific diagnosis or treatment that might be required and is given to authorize Riverside Christian School or the physician to exercise their best judgment for treatment.

This consent shall remain in continuous effect until revoked in writing and delivered to the physician named above or to the school or organization entrusted with the custody of said minor.

Parent/Guardian Signature:	Relationship:	Date:

This information is needed to keep your child healthy and safe while at school. If your child has a life threatening condition, it is the parent/guardian's responsibility to notify the school BEFORE school begins so that an appropriate plan of care is developed. A parent/guardian must carefully complete all the pages and return the forms with the completed registration packet.

MEDICAL HISTORY

Has your child been diagnosed by a licensed healthcare provider with any of the following?
Please mark **YES** or **NO** and explain all **YES** answers.

	YES	NO	Explanation
Anxiety			
Asthma			
Attention Deficit Disorder (ADD)			
Attention Deficit Hyperactivity Disorder (ADHD)			
Autism/Asperger's Syndrome			
Bladder/Bowel Concerns			
Blood Disorder			
Bone/Muscle Disease			
Cancer			
Cerebral Palsy			
Depression			
Diabetes			
Ear or Hearing Concerns			
Eating Disorders			
Emotional/Psychological Concerns			
Heart Condition			
Learning Disability			
Migraine or Severe Headaches			
Seizures			
Skin Conditions			
Other			

MEDICAL HISTORY (cont'd)

Does your child currently experience any of the following?
Please mark **YES** or **NO** and explain all **YES** answers.

	YES	NO	Explanation
Emotional Concerns			
Fainting Spells			
Frequent Ear Aches			
Frequent Headaches			
Frequent Stomach Aches			
Nose Bleeds			
Overweight for Age			
Physical Disability			
Poor Appetite			
Tires Easily			
Underweight for Age			
Other			
Has your child ever had any of the following?			
Serious Illness			
Serious Injury			
Surgery			
Hospitalization			

ALLERGIES

Please mark any known allergies:

❑ Plants/pollen ❑ Animals ❑ Food ❑ Molds ❑ Drugs ❑ Bees ❑ other _____

Please describe the allergic reaction and treatment:

HEARING/VISION

Do you have concerns about your child's hearing? ❑ Yes ❑ No

Does your child wear hearing aids? ❑ Yes ❑ No

Do you have concerns about your child's vision? ❑ Yes ❑ No

Does your child wear glasses or contacts? ❑ Yes ❑ No

SPEECH/LANGUAGE
Do you have concerns about your child's speech and/or language? ❑ Yes ❑ No
Do others have difficulty understanding your child? ❑ Yes ❑ No
LIFE-THREATENING CONDITIONS
Does your child have a life-threatening condition? ❑ Yes* ❑ No **If yes, a meeting with the school staff is required. Washington State Law requires that medication or treatment orders and a health care plan be in place prior to starting school.*
Please describe the condition:
MEDICATION
Does your child take any medications? ❑ Yes ❑ No
If yes, name of medication(s):
Will medication need to be taken while at school? ❑ Yes* ❑ No **If your child needs to take medication at school, please contact the office for the necessary authorization form. This form must be completed <u>prior</u> to the administration of any medication at school.*

I understand that the information above will be shared in a confidential manner with appropriate school staff to provide for the health and safety of my child. I will keep the school informed throughout the year regarding any changes in health status/contact information.

Parent/Guardian Signature:	Relationship:	Date: