



# TRADERS POINT CHRISTIAN ACADEMY

## Student Medical Emergency Information

Each student enrolled at Traders Point Christian Academy must have this signed release form filled out each year and on file.

Student's Legal Name: \_\_\_\_\_

Grade for 2010-2011: \_\_\_\_\_

Date of Birth (mm/dd/yyyy): \_\_\_\_\_

Local Emergency Contacts		
Name & Relationship to Student	Phone Numbers	
1. Parent/Guardian	Cell: Work:	Home: Other:
2. Parent/Guardian	Cell: Work:	Home: Other:
3. Local Emergency Contact/Relationship	Cell: Work:	Home: Other:
4. Local Emergency Contact/Relationship	Cell: Work:	Home: Other:

Name of family doctor: \_\_\_\_\_

Phone number: \_\_\_\_\_

Name of student's dentist: \_\_\_\_\_

Phone number: \_\_\_\_\_

Preferred hospital: \_\_\_\_\_

Date of last tetanus shot: \_\_\_\_\_

Allergies please explain what type of allergies, reactions, and what precautions need to be taken while at school: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Chronic Health Problems please explain any health conditions and special instructions: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List All Medications use back side for more room; please specify if medications will be taken at home and/or school:

Name	Dosage	Frequency	Times Taken	Purpose	Taken at Home/School

In case of an emergency involving your child, it is the policy of TPCA to render first aid treatment while contacting parents/guardians for further instructions. In the event that the parents/guardians cannot be contacted, designated employees of TPCA will see that the child is transported to the nearest clinic or hospital (unless indicated otherwise below). Once there, the employee will authorize medical treatments or procedures that, in the opinion of the attending physician, are necessary for the child's safety. (e.g. x-rays, anesthetic, medical or surgical diagnosis or treatment). This step will be taken only after all emergency contacts have been exhausted or if the school has received no instructions in a reasonable amount of time. Information on this form may be shared with the appropriate TPCA and EMS personnel for health and emergency purposes.

Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_



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## CHIRP Consent and Release Form

I, \_\_\_\_\_, give Traders Point Christian Schools, Inc. permission to release the following information concerning my child \_\_\_\_\_ to the Indiana State Department of Health's Children and Hoosiers Immunization Registry Program (CHIRP):

- Child's Name
- Immunization Data
- Date of Birth
- Demographic Data, including but not limited to:
  - Parent/Guardian Name (s)
  - Address
  - Phone Number
  - Race/Ethnic Background

I understand that the information in the registry may be used to verify that my child has received proper immunizations and to inform me or my child of my child's immunization status or that an immunization is due according to recommended immunization schedules.

I understand that my child's information may be available to the immunization data registry of another state, a healthcare provider or a provider's designee, a local health department, an elementary or secondary school, a child care center, the office of Medicaid policy and planning or a contractor of the office of Medicaid policy and planning, a licensed child placing agency, and a college or university. I also understand that other entities may be added to this list through amendment to I.C. 16-38-5-3.

I hereby consent to the release of such information.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Address

(\_\_\_\_\_) \_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
Child's Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
School

\_\_\_\_\_  
Grade Level



# TRADERS POINT CHRISTIAN ACADEMY

## Immunization Record

Student's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**Immunization dates should include month/day/year, e.g., 1/1/08. The following immunizations (or boosters) are required before school enrollment:**

<b>Primary Series:</b>	#1: _____	#2: _____	#3: _____
Diphtheria			
Tetanus			
Pertussis			
<b>DPT Boosters:</b>	#4: _____	#5: _____	_____
OR			
<b>D/T Booster:</b>	#4: _____	#5: _____	_____
<b>Primary Series:</b>	#1: _____	#2: _____	#3: _____
Polio			
<b>Polio Booster:</b>	#4: _____	_____	_____
<b>MMR:</b>	#1: _____	#2: _____	
<b>Chickenpox Vaccine:</b>	#1: _____	#2: _____	
OR			
<b>Date of Disease:</b>	_____		
	(Month/Year)		
<b>Hepatitis B:</b>	#1: _____	#2: _____	#3: _____
3 Dose Series:			
2 Dose Series:	#1: _____	#2: _____	
<b>HIB:</b>	#1: _____	#2: _____	#3: _____
(required for Pre-K)			
	#4: _____		
<b>PCV7:</b>	#1: _____	#2: _____	#3: _____
(required for Pre-K)			
	#4: _____		
<b>Hepatitis A*</b>	#1: _____	#2: _____	
<b>HPV*</b>	#1: _____	#2: _____	#3: _____
<b>Menactra (Meningitis)*</b>	_____	_____	
<b>TB Skin Test*</b>	_____	Results: _____	
<b>Sickle Cell Test*</b>	_____	<b>Lead Poisoning Test*</b>	_____

Does this child have any Medical Exemptions to any of the above immunizations? If so, please specify medically contraindicated reason why: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Physician's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

\*At the doctor's discretion



# TRADERS POINT CHRISTIAN ACADEMY

## Religious Objection

Student's Name: \_\_\_\_\_

Grade: \_\_\_\_\_

In accordance with Indiana immunization laws, specifically IC 20-34-3-2, based on religious grounds, I/we choose not to immunize my/our child named above to the specified immunizations:.

\_\_\_ Diphtheria

\_\_\_ Measles

\_\_\_ Pertussis

\_\_\_ Mumps

\_\_\_ Tetanus

\_\_\_ Rubella

\_\_\_ Polio

\_\_\_ Hepatitis B

\_\_\_ Meningitis

\_\_\_ Varicella

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\*If only one parent/guardian signature obtained, please indicate reason.



# TRADERS POINT CHRISTIAN ACADEMY

Physical Examination Form

A Physical Examination is required when:

1. A child enrolls at TPCA, regardless of grade level
2. Participating in competitive sports (required annually)
3. A child is excluded from P.E (must have a doctor's written statement)

Student's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Skin/Scalp: \_\_\_\_\_

Ears/Nose/Throat: \_\_\_\_\_

Mouth/Gums/Teeth: \_\_\_\_\_

Lymph nodes: \_\_\_\_\_

Heart/Blood Pressure: \_\_\_\_\_

Lungs: \_\_\_\_\_

Abdomen: \_\_\_\_\_

Genitalia: \_\_\_\_\_

Musculoskeletal: \_\_\_\_\_

Neurologic: \_\_\_\_\_

Speech: \_\_\_\_\_

Hearing: \_\_\_\_\_

Vision: \_\_\_\_\_ R: \_\_\_\_\_ L: \_\_\_\_\_

Known Allergies and Reaction: \_\_\_\_\_

Chronic Disease/Illness: \_\_\_\_\_

Current/Routine Medications: \_\_\_\_\_

Does this child have any health conditions that would keep him/her from participating in physical education class? If so, Please explain any necessary restrictions: \_\_\_\_\_

Comments/Recommendations: \_\_\_\_\_

I certify that I have personally examined the above named child and that I have found no medical reason why this child should be disqualified from participating in any competitive athletics unless otherwise stated above.

Physician's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_