Oregon Pupil Medical Record

Greater Portland Christian Academy

Form must be filled out by the child's parent or legal guardian.

Pupil's Name: _____ _____ _____ Date: _____
First Last Middle Initial

Sex (circle one) M F Birth Date: _____ Home Phone: _____

Address: _____ City: _____St:____ Zip: _____

Parent/Guardian Information

Father's Name: _____ _____ Business Phone: _____
First Last Cell Phone: _____

Mother's Name: _____ _____ Business Phone: _____
First Last Cell Phone: _____

Emergency Contact Information

Name: _____ _____ Phone: _____
First Last

Address:_____ City: _____St:___ Zip: _____

Physician: _____ Phone: _____

Dentist: _____ Phone: _____

I hereby give permission for my child to receive emergency medical care and for information on this document to be made available to school and health department authorities.

_____ _____
Signature of parent or legal guardian Date

Health Problems/Conditions/Allergies

Please list and explain any health problems or conditions that might require special planning or consideration for this child's participation in regular school activities. (examples: chronic disease, crippling conditions, sight or hearing problems, delayed development of bladder or bowel control or any condition requiring daily medication.)

_____

_____

_____

_____

_____
Signature of parent or legal guardian