

Faith Christian Academy
Emergency, Information and Immunization Record Card

Student Name:	Date of Birth: ____/____/____	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Home Address (#, Street, City, State, ZIP):		Updated: ____/____/____	Updated: ____/____/____
Home Phone:	Date Enrolled: ____/____/____	Updated: ____/____/____	Updated: ____/____/____

Parent or Guardian Name:	Home Address (#, Street, City, State, ZIP)		
Main Contact Phone Number:	Alternate Phone Number:	Alternate Phone Number:	

Parent or Guardian Name:	Home Address (#, Street, City, State, ZIP)		
Main Contact Phone Number:	Alternate Phone Number:	Alternate Phone Number:	

I authorize the following individuals to collect my child from this facility in case of emergency or if I (we) cannot be contacted (Please enter at least two contact persons).

Name:	Contact Number:
Name:	Contact Number:
Name:	Contact Number:
Name:	Contact Number:

Child's Health Care Provider: _____ Phone: _____

In the event of injury or sudden illness, the following should be called first:	Name:	Phone:
	Name:	Phone:

The following individual(s) may **NOT** remove my child from this facility:

Name:	Relationship:
Name:	Relationship:

If one of the names listed is on the child's birth certificate, custody papers have been provided and are on file at this facility. Yes No

One or more of these items must accompany the EIIR card at all times:

<input type="checkbox"/>	Copy of up-to-date official documented immunization record
<input type="checkbox"/>	Personal Beliefs Exemption Form signed by parent / guardian
<input type="checkbox"/>	Medical Exemption Form signed by physician and parent / guardian
<input type="checkbox"/>	Signed Laboratory Proof of Immunity Form for each required immunization

Notification of immunizations needed sent to parent(s) or Guardian(s):	mo/day/yr	mo/day/yr	mo/day/yr
Updated immunizations or exemption form received and attached:	mo/day/yr	mo/day/yr	mo/day/yr

Medical Information

Is the child allergic to food or other substances? If yes , describe symptoms, name foods or substances to be avoided, and the procedure to follow if reaction occurs:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is the child usually susceptible to infections and if so, what precautions need to be taken? If yes , list precautions:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is the child subject to convulsions and what should be our procedure if one occurs? If yes , specify procedure:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is there any physical condition that we should be aware of and what precautions should be taken (heart trouble, hearing impairment, hernia, etc.)? If yes , list precautions:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Additional comments	
Other special instructions:	

I verify that this **Emergency, Information, and Immunization Record Card** is accurate and complete, front and back, and was provided by:

Parent / Guardian PRINTED Name	SIGNED Name:	Date: ____/____/____
--------------------------------	--------------	----------------------