

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):		

Parent or Guardian Name:	Home Address (#, Street, City, State, ZIP) – <i>if different from student</i>	
Primary Phone: <input type="checkbox"/> Cell <input type="checkbox"/> Home	Secondary Phone: <input type="checkbox"/> Cell <input type="checkbox"/> Home	Work Phone:

Parent or Guardian Name:	Home Address (#, Street, City, State, ZIP) – <i>if different from student</i>	
Primary Phone: <input type="checkbox"/> Cell <input type="checkbox"/> Home	Secondary Phone: <input type="checkbox"/> Cell <input type="checkbox"/> Home	Work Phone:

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:	<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work
Name:	<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work
Name:	<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work
Name:	<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work
Name:	<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work
Name:	<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work

<u>Call in permission to pick up</u>	
Name _____	
Number _____	
Date ____/____/____	

Name _____	
Number _____	
Date ____/____/____	

Name _____	
Number _____	
Date ____/____/____	

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 <u>and</u> parent / guardian
<input type="checkbox"/>	Signed Laboratory Proof of Immunity Form <u>for each required immunization</u>

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 – Read and complete:

Is the child allergic to food or other substances (including medications)? 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
Requires an Epi-Pen? <input type="checkbox"/> Yes <input type="checkbox"/> No	Requires an Inhaler? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is there any physical or medical condition that we should be aware of and what precautions should be taken (heart trouble, hearing impairment, hernia, etc.)? Please attach any additional pertinent information. If yes , describe and list precautions:		<input type="checkbox"/> Yes <input type="checkbox"/> No
Additional comments		

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	Signature:	Date: ____/____/____
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