Send documentation to:
Redemption Christian Academy PO Box 753 Troy, NY 12181
Phone: 518-272-6679
Fax: (518) 270-8039
Email:admissions@redemptionchristianacademy.org

Redemption Christian Academy
Est. 1979

EMERGENCY CONSENT FORM

Student's Name_____ Date of Birth: _____/_____/_____
School Year 20_____ - 20_____ Grade:_____ Date of Last Tetanus _____ Soc. Sec. #_____

EMERGENCY CONSENT AND AUTHORIZATION FORM

We, the undersigned parent(s) or guardian(s) of the above named student, do hereby, consent to any x-ray, examination, anesthetic, medical or surgical diagnosis or treatment and hospital service that may be rendered necessary for the above named student under the general or special instructions of any physician the school may call, whether such diagnosis or treatment is rendered at the office of the physician or at a licensed hospital.

It is further understood that this consent is given in advance of any specific diagnosis or treatment which might be required and is given to authorize Redemption Christian Academy or the physician to exercise their best judgment as to the requirements of such diagnosis or treatment.

We, hereby, authorize any hospital, physician, or other person who has attended or examined the student to furnish to any appropriate insurance company, or its representatives, any and all information with respect to any illness, medical history, consultation, prescription, or treatment, and copies of all hospital or medical records. In case of no insurance, we agree to take full responsibility for all financial obligations incurred during treatment and/or hospitalization of the above mentioned student.

This consent shall remain in continuous effect until revoked in writing. A photostatic copy of this authorization shall be considered as effective and valid as the original.

TO BE COMPLETED BY PARENT OR GUARDIAN:

Father/Guardian _____ Social Security #_____
Mother/Guardian _____ Social Security #_____
Address of Parent/Guardian _____ Telephone (home)_____
_____
In case of emergency _____ Telephone (home)_____
Contact person/relationship _____ Telephone (work) _____

In case of emergency _____ Telephone (home)_____
Contact person/relationship _____ Telephone (work) _____

In case of emergency _____ Telephone (home)_____
Contact person/relationship _____ Telephone (work) _____

Medical/Accident Ins. Company _____
Address_____
Name of Insured: _____
Person carrying policy:_____ Policy Number_____
Family Physician _____ Telephone_____

Signature of Parent/Legal Guardian **Date**

Send documentation to:
Redemption Christian Academy PO Box 753 Troy, NY 12181
Phone: 518-272-6679
Fax: (518) 270-8039
Email:admissions@redemptionchristianacademy.org

Redemption Christian Academy
Est. 1979

STUDENT HEALTH INFORMATION (To be completed by a parent)

Student's Name_____ Date of Birth: _____/_____/_____

1. **Please state any known allergies:** _____
   Type of reaction(s) _____

2. Has/does your child had/have any of the following? (Check where appropriate.)

{ } Anemia	{ } Ear Infections (frequent)	{ } Sickle Cell Anemia
{ } Asthma	{ } Hearing Problems	{ } Speech Dysfunction
{ } Bronchitis	{ } Heart Problem	{ } Tonsillitis (frequent)
{ } Diabetes	{ } Learning Disability	{ } Vision Problem
{ } Dyslexia	{ } Seizures/Convulsions	{ } 4 or more colds yearly
{ } Fainting Spells	{ } Abdominal Pains	{ } Frequent urination
{ } Persistent cough	{ } Tires easily	{ } Frequent leg pains
{ } Ring worm	{ } Nose bleeding	{ } Growing pains

3. Menstrual Cramps { } Severe { } Moderate { } Mild

4. Has your child had (check where appropriate)

{ } Chicken Pox	{ } Measles (German)	{ } Rheumatic Fever
{ } Epilepsy	{ } Measles (Red)	{ } Scarlet Fever
{ } Hernia Repair	{ } Mumps	{ } Tuberculosis (TB)

5. Does your child take medication?_____Name, dosage, and frequency of medication_____

6. Has your child been hospitalized for any reason since birth? _____ If yes explain: _____
_____

7. Are there any problems/concerns in the home which might affect your child's learning? _____
If yes, explain: _____

8. Is there anything more about your child's health that you think is important for us to know?
_____
_____
_____

9. Does your child use prescription glasses? _____

Signature of Parent/Legal Guardian **Date**

Send documentation to:

Redemption Christian Academy PO Box 753 Troy, NY 12181
Phone: 518-272-6679
Fax: (518) 270-8039
Email:admissions@redemptionchristianacademy.org

Redemption Christian Academy
Est. 1979

PHYSICAL EXAMINATION *(To be completed by a physician)*

Student's Name_____ Date of Birth: _____/_____/_____

Height	Weight	Vision				Hearing	
		Without glasses		With glasses		Right	Left
_____in.	_____lbs.	right	left	right	left	_____	_____
		20/__	20/__	20/__	20/__	method used:_____	

Instructions: Describe fully any abnormal findings:

Blood Pressure: _____

Heart Rate: _____

General: _____

Appearance: _____

Skin: _____

HEENT

Head _____

Eyes _____

Nose/Throat _____

Teeth/Mouth_____

Chest/Lungs_____ _____

Cardiovascular_____

Abdomen_____

Genitalia _____

Extremities _____

Joint/Spine_____

Neurological_____

Behavior _____

Required Medication _____

_____

Physician's Signature:_____ Telephone:_____ Date:_____

Please enclose a current copy of the student's immunization record and medical history.

Send documentation to:

Redemption Christian Academy PO Box 753 Troy, NY 12181
Phone: 518-272-6679
Fax: (518) 270-8039
Email:admissions@redemptionchristianacademy.org

Redemption Christian Academy
Est. 1979

AUTHORIZATION TO PARTICIPATE IN SPORTS (To be completed by a physician)

Student's Name_____ Date of Birth: _____/_____/_____

1.	Has had injuries requiring medical attention?	_____Yes	_____No
2.	Has had illness lasting more than a week?	_____Yes	_____No
3.	Is under a physicians care now?	_____Yes	_____No
4.	Takes medication now?	_____Yes	_____No
5.	Wears glasses?	_____Yes	_____No
	Contact Lenses?	_____Yes	_____No
6.	Has had a surgical operation?	_____Yes	_____No
7.	Has been in a hospital (except for tonsillectomy)?	_____Yes	_____No
8.	Do you know of any reason why this individual should not participate in sports?	_____Yes	_____No
9.	Has ever been knocked out or had a concussion?	_____Yes	_____No
10.	Allergies to any medicines? (examples: aspirin, Tylenol)	_____Yes	_____No
11.	Missing any paired organs?	_____Yes	_____No
12.	Wears any dental appliance such as a crown, bridge, partial or full plate?	_____Yes	_____No
13.	Most recent tetanus toxoid (date)_____		
	Booster required only every ten years.	_____Yes	_____No

Please explain any yes answers to the above questions: _____

_____

Student Participation:
This application to compete in interscholastic athletics for the school year 20_____ - 20_____ for the Redemption Christian Academy is entirely voluntary on my part and is made with the understanding that I have not violated any of the eligibility rules and regulations.

_____
Signature of Student

Parent/Guardian Approval:
I hereby give my consent for the above named student (1) to represent his/her school for the school year _____ in _____ (2) to accompany any school team of which he or she is a member of to any of its local or out-of-town trips. I authorize the school to obtain, through a physician of its own choice, any emergency medical care that may become reasonably necessary for the student in the course of such athletic activities or such travel. I also agree not to hold the school or anyone acting in its behalf responsible for any injury occurring to the above-named student in the course of such athletic activities or such travel.

_____ _____
Typed or printed name of parent/guardian **Signature of parent or guardian**

_____ _____
Health/Accident/Hospitalization Insurance Date

Physician Approval:
I hereby affirm that this student has received a complete physical and is deemed physically fit to participate in:
Name of Sport _____

Signature of Physician:_____ Date:_____