

23 Grove Street
Bayville, NJ 08721
www.hillcrestchild.com



Phone: 732-269-8585
Fax: 732-269-7592
hillcrestchild@optonline.net

HILLCREST ACADEMY MEDICAL RELEASE FORM

Child's Full Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____

Parent 1: _____ Parent 2: _____

Home Phone: _____ Cell Phone (P1): _____ Cell Phone (P2): _____

Work Phone (P1): _____ Work Phone (P2): _____

Allergies: _____

Emergency Contact Name: _____ Relationship to Child: _____

Home Phone: _____ Cell Phone: _____

Address: _____ City: _____ State: _____

Child's Physician: _____ Physicians Phone Number: _____

Medical Insurance Company: _____ Phone: _____

Policy Holder: _____ Policy #: _____ Group #: _____

EMERGENCY AND MEDICAL PROCEDURE

1. IN CASE OF ILLNESS, I understand that I will be called and required to pick up my child within the one hour acceptable time response.
2. IN CASE OF SIMPLE INJURY, (such as abrasions, skinned knees, splinters, etc) I understand that the school staff will perform routine hygienic measures, such as washing wounds and apply Band-Aids.
3. IN CASES REQUIRING THE ATTENTION OF A PHYSICIAN (stitches, X-rays, etc), I understand that the school staff will call me first and if I cannot be reached please call the listed emergency contact. If no one can be reached, I give my permission for Dr. _____, whose office phone number is _____ to be called and for that doctor to render necessary treatment.

MEDICAL RELEASE

In the event that a medical emergency occurs, I authorize Hillcrest Academy to seek emergency medical care for my child as deemed necessary by the Director or Assistant Director.

1. Parent/Guardian Signature: _____ Date: _____

2. Parent/Guardian Signature: _____ Date: _____