Emergency Medical Authorization 2009-2010 Complete form in its entirety – Please PRINT

STUDENT/ FAMILY INFORMATION:

Full Name: ______________________________ Grade ________ Birth date __________ Sex ______

Address: ____
CITY STATE ZIP

Home Phone (________)____________________ I wish to be included in a class roster (student & parent names & phone #) available only to others in the same grade ❒Yes ❒No

Who is/are the legal guardian(s) of this child ______________________________

Relationship to child ______________________________ Resides with the child? Yes ________ No ________

Father's name: ______________________________ Employer: ______________________________

Work Phone ____________________ Cell Phone ____________________ E-mail ____________________

Mother's name: ______________________________ Employer: ______________________________

Work Phone ____________________ Cell Phone ____________________ E-mail ____________________

Emergency Contacts: Parents cannot be listed as emergency contacts. List the name of at least two people (not residing at the family address) who you want to be contacted in the event of an emergency or illness if the parent/guardian cannot be reached. Persons listed should be able to assist in locating the parent/guardian and be able to take responsibility for the child in cases where the parent/guardian cannot be located.

Name	
Address	
City ST Zip	
Phone	Relationship to child
Other numbers where this contact may be reached	

Name	
Address	
City ST Zip	
Phone	Relationship to child
Other numbers where this contact may be reached	

I understand that if my child becomes ill or injured and must leave school, he or she may only be released to those indicated above.

Signature of Parent/Guardian

______________________________ Date ____________

Complete Part I or Part II and Part III

Part I: TO GRANT CONSENT

The parents/guardians of the student named above hereby give consent for and fully authorize any first aid that may become necessary for the student. Additionally, in the event that reasonable attempts to contact the parents/guardians are unsuccessful, the parents/guardians hereby give consent for and fully authorize (1) emergency medical care (including X-ray examination, anesthetic, hospital/medical treatment) prescribed by a duly licensed physician or dentist. This care may be given under whatever conditions are necessary to preserve the life, limb, or well-being of the student; and (2) the transfer of the child to any hospital reasonably accessible. This authorization does not cover major surgery **unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity of such surgery, are obtained prior to the performance of the surgery**. I accept the cost of any such treatment and, with regard to such treatment, release from responsibility and financial liability Bethlehem Christian Academy, including its administrators, faculty, staff, and other designated leaders.

Parent/Guardian Signature ______________________________ Date: ____________

Part II: REFUSAL OF CONSENT:

I do NOT give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish school authorities to take the following action:

____

Parent/Guardian Signature: ______________________________ Date: ____________

Part III: Health Information – All information, including phone numbers, must be completed.

Please note the following health conditions:

(allergies) ______________________ (physical limitations) ______________________

(special medication) ______________________ (chronic conditions) ______________________

Child's Physician: ______________________ Phone # ______________________

Child's Dentist: ______________________ Phone # ______________________

Preferred Hospital: ______________________ ER Phone # ______________________

Health Insurance Provider: ____