

HERITAGE CHRISTIAN SCHOOL
Authorization for Emergency Medical Care

Student Name: _____ Birth Date: _____

Parent(s) Name: _____ Student's Grade: _____

Complete address: _____
(Street or P.O. Box) (City) (State) (Zip)

Home phone: _____ Cell phone: _____

Place of employment: _____ Phone: _____

In case of emergency in which parents cannot be reached, the following person(s) should be contacted:

Name: _____ Relation to child: _____

Complete address: _____
(Street or P.O. Box) (City) (State) (Zip)

Home phone: _____ Cell phone: _____

Place of employment: _____ Phone: _____

Names of persons authorized to drop off or pick up student from school other than parent:

<u>Name</u>	<u>Relation to child</u>	<u>Phone</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please check all that apply.

- My child has: _____ Hearing problems
_____ Vision problems
_____ Attention Deficit Disorder
_____ Allergies to: _____
_____ Other chronic medical condition: (Example: asthma, diabetes, epilepsy, heart condition.) Please explain. _____
_____ Medication(s): _____

(Continued on reverse side)

In the event that my child becomes ill or is injured at school or a school activity and neither parent, emergency contact, nor doctor named below can be reached, I authorize Heritage Christian School, its staff and faculty members to obtain all medical care deemed necessary for my child and authorize any licensed physician and/or medical personnel to render emergency medical treatment.

_____ Yes _____ No

I agree to assume financial liability for any and all expenses incurred because of an accident, injury, illness, or other unforeseen circumstances that is not the result of fraud, willful injury to a person or property, or the willful or negligent violation of law.

_____ Yes _____ No

I give consent for my child to receive aspirin (acetaminophen, ibuprofen) at school from the school staff in the amount recommended for his/her age and weight per package instructions provided that the school staff will contact me before administering.

_____ Yes _____ No

Parent/Guardian's Signature

Date

For hospital information, my child is covered under the following health insurance:

Insurance Company (if applicable)

Policy #

Name of Family Doctor

Office Address

Phone