EDUCATING STUDENTS TO IMPACT THE WORLD FOR CHRIST

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:

Name	Relation to child	Phone

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 (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

Rev.05/14