

Emergency Medical Authorization 2017-2018 Complete form in its entirety – Please PRINT

STUDENT/ FAMILY INFORMATION:

Full Name: _____ Grade _____ Birth date _____ Sex _____

Address: _____

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	

Signature of Parent/Guardian _____

Date _____

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.

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: _____