Authorization for Medical Treatment

Christian Family Academy 2024-2025

Students Full Legal Name: ____ **Grade:** ______________

Date of Birth: _____________________________ **Social Security #**_______________________________

Emergency Phone Numbers:

Father at Work: __________________________ Home: __________________________ Cell______________________

Mother at Work: _________________________ Home: __________________________ Cell______________________

If parents cannot be contacted, indicate responsible adults to contact in case of emergency. These persons also have permission to pick up your child from school, in the event you are unable to do so.

Emergency Contact 1: Name: ______________________________ Relationship: _______________________________

Home: ___________________________ Work: ___________________________ Cell: __________________________

Emergency Contact 2: Name: ______________________________ Relationship: _______________________________

Home: ___________________________ Work: ___________________________ Cell: __________________________

Name of Medical Insurance Co.: ____

Policy Number: ____________________________ Expiration Date: _____________

Name of Family Physician: _________________________________ Phone: ______________________

Is the student on any medication? ______ Specify: ____

Does your child have any allergies? _______ If yes, please explain: ____

Is there any other medical information that you feel we should have about your child? __________________________________

____

- -

I hereby give my consent to any emergency facility and physician to administer necessary treatment to my child ____, in the event of an emergency at which time I cannot be reached. I give consent to transport by ambulance if the situation warrants.

Parent/Guardian's Signature ____ ***Date***___________________________