

2011-2012

EMERGENCY INFORMATION MEDICAL AUTHORIZATION

Child's Name (Last)		(First)	(MI)	Date of Birth		Sex (M) (F)		Grade:
Parent/Guardian (Mother)	Address		Home #		Work #		Cell #	
(Father)	Address		Home #		Work #		Cell #	
Emergency Contact Person:	Authorized to drive child?		Home #		Work #		Cell #	
Relationship:	(yes) (no)							
Insurance Co.		Date of Last Tetanus Booster		*EPI PEN (Yes) (No)		*Asthma (Yes) (No)		*Needs Inhaler (Yes) (No)
*Allergies (Yes) (No)	Describe							

This emergency information must be in the teacher's possession in order for students to be allowed to go on class trips

***A parent must accompany any student with medical conditions that require possible treatment on all class trips**

Should my child become ill or injured while under supervision at school or on a field trip, I approve of the school administering minor first aid and when indicated, to contact parent/guardian or other authorized individuals as listed above.

In the event of an emergency, when a parent or guardian cannot be reached immediately, the school authorities are hereby authorized to use their best judgment in securing the services of a properly licensed physician or dentist or in transporting my child to the hospital or medical facility for consultation and/or treatment. Such transporting is to be done either by school provided transportation or, if school officials deem it preferable, by ambulance.

If, in the opinion of a properly licensed practicing physician, my child needs medical or surgical services which require my consent before being supplied, and I cannot be reached, I authorize the administrator or his/her designated representative, to furnish on my behalf such written or oral authorization as may be required by the medical facility.

Furthermore, I release the administrator or his/her designated representative and American Christian School, including the officers of the American Christian School Society, Inc., from any liability which might arise as the result of medical service and treatment provided by any physician or hospital or medical facility pursuant to such authorization, it being my desire that my child be furnished with such medical or surgical services as soon as possible after the need arises. I agree to be responsible for any cost of medical service or treatment of my child as the result of the above authorization and agree to indemnify and hold harmless American Christian School Society, Inc., the administrator, or his/her representative from any expense incurred for said treatment or services.

As Parent/Guardian of the above named student, I hereby authorize the release of pertinent medical information (medical conditions, allergies, and/or medication regimes) to be exchanged between the school nurse and the child's medical doctor involved in the care of the above student. I give the school nurse permission to share my child's medical information with the principal/teacher/staff that has contact with my child during the school year. This exchange of medical information will be on an as needed basis only and held strictly confidential.

Signature Parent/Guardian _____

Date _____