EMERGENCY CONTACT INFORMATION

STUDENT INFORMATION

Name: ______________________ Date of Birth: ____________ Grade: _________

Allergies: ____

- If a prescription medication is to be administered during the school day, a medical release form must be signed. Please complete page 3.

PARENT INFORMATION

Parent/s: ____

Local Address: ____

Permanent Address: ____

____

Mailing Address: ____
(if different)

____

EMERGENCY CONTACT

Mother: Home/Work#: ______________________ Cell: ______________________

Father: Home/Work#: ______________________ Cell: ______________________

If parent is unavailable, emergency contact: ______________________

Emergency contact numbers: ______________________ or ______________________

Physician's Name: ______________________ Phone: ______________________

Insurance Company: ____

Policy Holder's Name: ______________________ Policy#: ______________________

Please list anyone besides the parent/s permitted to pick your child/ren up from school**:**

1. ______________________ Cell: ______________________
2. ______________________ Cell: ______________________
3. ______________________ Cell: ______________________

Parent Signature: ______________________ Date: ______________________

EMERGENCY MEDICAL AUTHORIZATION FORM

Purpose: To enable parents/guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents or guardians cannot be reached.

Student Name: ________________________ Date of Birth: _____________ Grade: ________

PART I: TO GRANT CONSENT

I DO give consent for the following medical care providers and local hospital to be called:

Physician's Name: ______________________________ Phone: _______________________

Dentist's Name: ________________________________ Phone: _______________________

Medical Specialist's Name: _______________________ Phone: _______________________

Local Hospital: ________________________________ Phone: _______________________

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by the above-named doctors, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) 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 for such surgery, are obtained prior to the performance of such surgery.

Facts concerning my child's medical history, including allergies, medications being taken, and any physical impairments to which a physician should be alerted:

____

____

Signature of Parent/Guardian: _______________________________ Date: _______________

PART II: REFUSAL TO 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 the school authorities to take the following action:

Signature of Parent/Guardian: _______________________________ Date: _______________

MEDICATION AUTHORIZATION FORM
(for use on/off Academy property)

Student Name: ________________________ Date of Birth: ______________ Grade: ________

1) Medication Name : ____

Dosage: ______________________________ Time: ________________

Dosage: ______________________________ Time: ________________

2) Medication Name : ____

Dosage: ______________________________ Time: ________________

Dosage: ______________________________ Time: ________________

I give permission to The Academy's representative (teacher/office staff) to dispense/administer the above medicine, as indicated. The medication/s supplied by me is in its original container.

To my knowledge, my child has no medical condition or allergies that contraindicate the use of said medicine/s.

I understand I may retrieve the medication/s from the school. However, medication/s will be destroyed if it is not picked up within one week of the date of this authorization. I understand that my child is not permitted to be self-medicated while on school grounds.

Parent Signature: ___________________________________ Date: _________________