AUTHORIZATION CONSENT FOR MEDICAL TREATMENT
2011-2012

(PLEASE PRINT IN **BLACK INK**)

I/We ____________________________and ___________________________ are the parent(s)/ legal guardian(s), with legal custody of

______________________________________, who is in the ______ grade. Home Phone: ____
(child's name)

____
(full address)

I/We give permission for my/our son or daughter to participate in any sports and/or school-sponsored activities on or off the school campus throughout the school year. A school representative will accompany students at all times.

Although the school desires to provide a safe and enjoyable time for all students, accidents can still happen. I/We understand that there are risks/dangers involved with participation in activities on or off the school campus. In consideration of my/our child being allowed to participate in these events, I/we assume responsibility for those normal operations associated with activities and travel. I/We agree not to hold liable **ELKHART CHRISTIAN ACADEMY**, its employees, coaches and representatives, including volunteer and other drivers, from any and all claims arising from my child's participation. This release agreement does not apply to claims of intentional (criminal) misconduct or gross negligence by the school, its employees, or volunteers. If such circumstance is proved in a court of law, I/we acknowledge and agree that the school can assume no financial liability beyond its actual liability insurance policy limits in force.

In case of accident, illness or other emergency, I/We give permission for a licensed doctor, or emergency treatment center selected by the school employee/coach/representative to administer the necessary attention and aid to my/our child should he/she become injured or sick during any school-sponsored activity. If a life-threatening emergency exists, I/we give permission for the school staff to call paramedics immediately and then contact me/us as soon as possible thereafter.

I/We authorize and consent to any X-ray examination, anesthetic, medical, dental or surgical treatment and hospital care which is in the best judgment of a licensed physician or dentist, deemed advisable. I/We agree to assume the financial responsibility for expenses incurred as a result of those services being provided. I/We also agree to be financially responsible for emergency medical transportation.

We understand the school coach/representative will endeavor to reach us should the nature of the injury or illness warrant it. However, I/we will not hold any of the school personnel responsible if efforts to contact me/us are unsuccessful. I/We give permission for the information on this form to be shared with appropriate school personnel as deemed necessary.

****If BOTH parents have guardianship, the consent form must be signed by BOTH parents/guardians.**

Date__________________ Father/guardian signature____

Date__________________ Mother/guardian signature____

Please mark which parent/guardian is to be called 1st if the school needs to get in contact with you about your student.

1st ❑ 2nd❑ 1st ❑ 2nd❑

Father's work phone: (_____)____________________________ Mother's work phone: (_____)________________________________

Father's cell phone: (_____) ____________________________ Mother's cell phone: (_____)________________________________

Father's pager #: (_____)_______________________________ Mother's pager #: (_____)__________________________________

****<u>OVER FOR MEDICAL INFORMATION</u>****

In case of an emergency, who is the nearest relative or neighbor to contact if we are unable to contact you at home or work?

________________________________ ___________________________ ____

Name Relationship Home Phone Cell Phone

Physician:____ Phone______________________________________

Dentist:____ Phone: ____________________________________

Medical insurance company:____ Policy #:___________________________________

Allergies (List **all,** with reaction): ____

____

____

Child is presently taking the following medication(s):____

____

for the following condition(s):____

____

____

Any new immunizations? Please List(name & date received):____

____

NON-PRESCRIPTION MEDICATION PERMISSION

If you wish for non-prescription medication to be administered to your child at school, if needed during the school year, (such as for a headache, stomachache or allergies), **please check below:**

______Ibuprofen (Advil, Motrin) ______Children's Pepto-Bismol Chewables

______Acetaminophen (Tylenol) ______Benadryl (Antihistamine)

______Antacid (Tums, Rolaids) ______Other **(Provide your own in original container)**

____Name of medication

____Dose/Time to administer

______Would prefer my child **not** receive non-prescription medication at school

If your child requires prescription medication or medication not listed above that will need to be administered during school hours, an additional form will need to filled out and signed. The forms are available in the office and on our website.

ADDITIONAL INFORMATION: ____

____

____

IF ANY IFORMATION CHANGES DURING THE SCHOOL YEAR (Phone #, etc.) PLEASE LET THE OFFICE KNOW AS SOON AS POSSIBLE.