

CHRISTIAN LIFE ACADEMY
Yearly Emergency Medical Consent Form

School Year: _____ **Grade:** _____ **Teacher:** _____

Student Name: _____ **Birthdate:** _____

Address: _____ **Phone:** _____

Guardian/Father _____

Place of Employment: _____ **Phone:** _____

Guardian/Mother _____

Place of Employment: _____ **Phone:** _____

Emergency Contacts if parent/guardian cannot be reached:

Name: _____ **Phone:** _____

Name: _____ **Phone:** _____

Does your child have any medical condition or allergies which may require medical treatment or to which a physician should be alerted? NO ___ YES ___ If YES, please explain _____

Related medications (name, dosage, frequency) _____

Emergency Consent:

In the event that I cannot be contacted, I hereby give my consent for :

- 1.) The administration of any treatment deemed necessary by
Dr. _____ (preferred physician) or
Dr. _____ (preferred dentist), or if they are unavailable, by
another licensed practitioner.
- 2.) the transfer of my child to: _____ (preferred
hospital) or 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 for such surgery, are
obtained prior to the procedure.)
- 3.) emergency transportation in a privately owned car or commercial vehicle at
my expense.

Refusal to Emergency Consent:

I do NOT give my consent for emergency medical treatment of my child. I wish
the school to take NO action or to

Parent/Guardian Signature _____ **Date:** _____