AUTHORIZATION FOR EMERGENCY CARE TO MINOR(S)

(One per Student)

Student_____ _____Grade_____

Last Name First Name Middle Name

Home Phone_____ Mother Work #_____ Father Work #_____

In case of emergency illness or accident, the child is given first-aid and the parents are notified. If the parent cannot be located, the child will be taken to the Emergency Room of your choice. Shiloh Christian School does not assume responsibility for the payment of hospital, doctor, or ambulance fees.

Health Insurance with:_____

Policy Holder:_____ Policy # :_____

I/We the undersigned, parent(s) or legal guardian of the minor(s) listed below:

_____ Birth Date_____

(Minor's Name)

It is understood that this consent is given in advance of any specific di agnosis or treatment being do hereby authorize any x-ray examination, anesthetic, dental, medical, or surgical diagnosis or treatment by any physician or dentist licensed by the State of Oklahoma and hospital service that may be rendered to said minor under the general, specific, or special consent of an acting agent of Shiloh Christian School, the temporary Custodian of the minor, whether such diagnosis or treatment is rendered at the office of the physician or dentist, or at a hospital licensed by the State of Oklahoma. I/We authorize the physician or dentist to call in any necessary consultants, in his/their own discretion. We further authorize said physician or dentist to exercise his/their discretion in authorizing the disposal of any severed tissues or member.

It is understood that this consent is given in advance of any specific diagnosis or treatment being required, but is given to encourage those persons who have temporary custody of the minor, and said physician and/or dentist to exercise his/their best judgment as to the requirements of such diagnosis or medical or dental or surgical treatment.

This consent shall remain effective from this date until **3:30p.m. on the 24th day of May 2016** unless sooner revoked in writing, delivered to said physician or dentist or to said persons entrusted with the custody, care, and control of said minor children. **To be signed and witnessed during registration.**

DATED_____ _____

Father

Witness: (Other than custodian(s) _____

Mother

_____ _____

Legal Guardian

AUTHORIZATION OF NON-PRESCRIPTION MEDICATION

The Staff of Shiloh Christian School has my permission to administer the following if needed to my child

	Yes	Initial	No	Initial
Tylenol	___	___	___	___

Known Medication or Food Allergies: _____

_____