



CHAPEL HILL CHRISTIAN SCHOOL

(Please also fill out reverse side)

Grade: _____
15-16

Emergency Contact and Medical Information for a Child

Child's Name	Date of Birth		M	F
			Sex	
Parent/Guardian Name	Parent/Guardian Name			
()	()	()	()	
Daytime Phone	Work Phone	Daytime Phone	Work Phone	
Cell Phone: ()	Cell Phone: ()			
Address	Address			
City, ST ZIP Code	City, ST ZIP Code			

*Alternative Emergency Contacts

*The listed persons have permission to make medical decisions and pick-up my child in the case of an emergency when I cannot be contacted.

Primary Emergency Contact	Secondary Emergency Contact
()	()
Daytime Phone	Daytime Phone
Work Phone	Work Phone
Cell: ()	Cell: ()
Address	Address
City, ST ZIP Code	City, ST ZIP Code

Medical Information

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

Hospital/Clinic Preference	Date of Last Tetanus Shot (DTaP)
Physician's Name	Phone Number
Dentist's Name	Phone Number
Allergies/Special Health Considerations	

Part I: Grant Consent:

I authorize (1) all medical and surgical treatment, X-ray, laboratory, anesthesia, and other medical and/or hospital procedures as may be performed or prescribed by the above-named doctor, or, in the event the designated practitioner is not available, by the attending physician and/or paramedics for my child and waive my right to informed consent of treatment, and (2) the transfer of my child to any hospital reasonably accessible. This waiver applies only in the event that neither parent/guardian can be reached in the case of an emergency.

Parent/Guardian Signature _____ Date _____

Part II: Refusal to Consent

I DO NOT authorize ANY emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish school authorities to take the following action:

Parent/Guardian Signature _____ Date _____

Please Complete The Reverse Side