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

( ) Daytime Phone

( ) Work Phone

Cell Phone: ( )

Address

City, ST ZIP Code

Parent/Guardian Name

( ) Daytime Phone

( ) Work Phone

Cell Phone: ( )

Address

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

( ) Daytime Phone

( ) Work Phone

Cell: ( )

Address

City, ST ZIP Code

Secondary Emergency Contact

( ) Daytime Phone

( ) Work Phone

Cell: ( )

Address

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