Valley Christian Academy
Emergency Medical Authorization
School Year _____

Student's Full Name _____ Birth date _____/_____/_____

Street _____City _____ State ____ Zip _____

Home Telephone (_____)_____

Father's (Guardian's) Name:	Daytime Phone:
Mother's Name:	Daytime Phone:
Emergency Contact #1:	Daytime Phone:
Emergency Contact #2:	Daytime Phone:

PURPOSE: This form enables parents to authorize emergency treatment for children who become ill or injured while under school authority, when parents cannot be reached.

Either Part I -or- Part II MUST BE COMPLETED.

PART I: TO GRANT CONSENT

I hereby give consent for the following medical care providers and hospital to be called if parents cannot be reached:

Doctor:	Phone:
Dentist:	Phone:
Medical Specialist:	Phone:
Local Hospital:	Emergency Room Phone:

In the event reasonable attempts to reach the Emergency Contacts listed above have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by the above named doctor or dentist, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist and (2) the transfer of the child to the above named 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 before the surgery is performed.

Facts concerning the child's medical history: including allergies, medications being taken, and any physical impairment to which a physician should be alerted:

_____

_____

Date of last Tetanus shot: ____/____/_____ Parent (Guardian) Signature _____

Address_____

WE MUST HAVE THESE DATES. Date signed _____/_____/_____

(over)

PART II: <u>REFUSAL TO CONSENT</u>

(Do not complete Part II if you completed Part I)

I DO NOT give consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take NO action or to :

_____

_____

Date of last Tetanus shot: ____/____/____ Parent (Guardian) Signature _____

Date of last MMR: _____/_____/_____ Address _____

WE MUST HAVE THESE DATES. Date signed _____/_____/_____