2018-2019 School Year

AUTHORIZATION FOR MEDICAL TREATMENT

To be completed by parents of applicant

DATE: _____/_____/_____ (**Please Complete One per Child**)

Student Name: _____ Grade:_____

I do hereby certify that I am the natural parent or legal guardian of the above named minor child, who is attending The King's Christian Academy.

Parent/Guardian Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Cell: _____

In the event that either parent or guardian of the above named child is not immediately available:
I/We hereby authorize any qualified member of a hospital emergency room (Armed Forces or private), or rescue squad to render any required first aid treatment that they believe is necessary for the above named minor dependent.

I further authorize the above named medical personnel to perform treatment which includes all types of minor surgery, cleansing of wounds, minor incisions and suturing when necessary in the opinion of the person rendering the treatment, and the person rendering the treatment is professionally qualified to perform such acts, but I restrict the granting of major surgery until I have executed a special release for that specific surgery.

This limited power of attorney is given until my dependent has reached the legal age of consent or until I revoke this document.

Signature of Parent or Legal Guardian:_____

Date:_____ Witness Signature:_____

Does your child have any allergies or health alerts we should be aware of? □Yes □No

If yes, explain_____

_____

Is your child on any medications? □Yes □No

If yes, explain_____

_____

Insurance Policy Number:_____

Name of Insurance Policy:_____