Authorization for Medical Treatment ***Christian Family Academy 2025-2026***

Students Full Legal Name: ____ **Grade:** _______________

Date of Birth: ______________________________ **Social Security #**________________________________

Emergency Phone Numbers:

Father at Work: ___________________________ Home: ___________________________ Cell_______________________

Mother at Work: ___________________________ Home: ___________________________ Cell_______________________

If parents cannot be contacted, indicate responsible adults to contact in case of emergency. These persons also have permission to pick up your child from school, in the event you are unable to do so.

Emergency Contact 1: Name: _______________________________ Relationship: ________________________________

Home: ____________________________ Work: ____________________________ Cell: ___________________________

Emergency Contact 2: Name: _______________________________ Relationship: ________________________________

Home: ____________________________ Work: ____________________________ Cell: ___________________________

Name of Medical Insurance Co.: ____

Policy Number: _____________________________ Expiration Date: ______________

Name of Family Physician: __________________________________ Phone: _______________________

Is the student on any medication? ______ Specify: ____

Does your child have any allergies? _______ If yes, please explain: ____

Is there any other medical information that you feel we should have about your child? ___________________________________

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I hereby give my consent to any emergency facility and physician to administer necessary treatment to my child ____, in the event of an emergency at which time I cannot be reached.

I give consent to transport by ambulance if the situation warrants.

Parent/Guardian's Signature ____ ***Date***___________________________