

**Emergency Medical Authorization Form**  
**(All blanks must be completed)**

201\_\_\_\_ - 201\_\_\_\_ School Year for the \_\_\_\_ Grade

**Child's Legal Name** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_

Student's home phone: \_\_\_\_\_ Student's home address: \_\_\_\_\_

Father's work phone: \_\_\_\_\_ Father's cell phone: \_\_\_\_\_ Email: \_\_\_\_\_

Mother's work phone: \_\_\_\_\_ Mother's cell phone: \_\_\_\_\_ Email: \_\_\_\_\_

This form will be on file at the school office for the current school year. **An additional Off-Campus Permission Form** will be sent home prior to each off-campus trip.

I give my permission for my child, as listed above, to participate in all sports and school-sponsored trips away from the school premises throughout the current school year. Students will be accompanied by a teacher and will be under adequate supervision. I understand that I will be given prior notice of all trips away from the school premises. I understand that I may revoke permission for a specific field trip by written notice hand-delivered to the administration more than one day prior to the trip.

Although the school desires to provide a safe and enjoyable time for all students, accidents can still happen. I/we understand there are risks/dangers involved with participation in on-campus activities and off-campus trips and their associated activities. In consideration of my child being allowed to participate in these events, I/we assume responsibility for those ordinary and reasonable risks associated with the travel and activities. I/we agree to hold harmless Bethesda Christian School, its affiliated organizations, employees, agents, and representatives, including volunteer chaperones, from any and all claims arising from my child's participation.

In case of accident, illness, or other emergency, I/we request that the school contact me/us. If the school cannot reach a parent/guardian after conscientious effort, I/we give permission for school staff to call paramedics or any licensed physician or dentist. If a life-threatening emergency exists, I/we give permission for school staff to call paramedics immediately and then contact me/us as soon as possible thereafter.

I/we authorize and consent to any X-ray examination, anesthetic, medical, dental, or surgical diagnosis or treatment, and hospital care which, in the best judgment of a licensed physician or dentist, is deemed advisable. I/we agree to assume the financial responsibility for expenses incurred as a result of those services being provided. I/we also agree to be financially responsible for emergency medical transportation.

\_\_\_\_\_/\_\_\_\_\_  
Father/Guardian's Signature Date

\_\_\_\_\_/\_\_\_\_\_  
Mother/Guardian's Signature Date

Father's Name Printed: \_\_\_\_\_

Mother's Name Printed: \_\_\_\_\_

**If the child lives with both parents, the release must be signed by both parents/guardians.**

**Witness must be 18 years or older.**

Witnessed by: \_\_\_\_\_

Date: \_\_\_\_\_

Doctor: \_\_\_\_\_

Phone: \_\_\_\_\_

Dentist: \_\_\_\_\_

Phone: \_\_\_\_\_

Health Insurance Carrier: \_\_\_\_\_

Group: \_\_\_\_\_ Policy #: \_\_\_\_\_

Under the name of: \_\_\_\_\_

Relationship: \_\_\_\_\_

Hospital: \_\_\_\_\_

In case of emergency, who is your nearest relative or neighbor we should contact if we are unable to contact you:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

**Medical/Health Information**

Date of last tetanus shot (DTaP, DT, or Tdap): \_\_\_\_\_ (For hospital emergency room visit – This is required!)

Is your child allergic to any medication, foods, animals, insects, or anything else? \_\_\_\_\_ No \_\_\_\_\_ Yes

If yes, please list with care required: \_\_\_\_\_

Does your child take medication regularly? \_\_\_\_\_ No \_\_\_\_\_ Yes

If yes, please list medication and explain: \_\_\_\_\_

Please check any of the following that your child has currently or previously experienced:

- \_\_\_\_\_ ADD / ADHD      \_\_\_\_\_ Diabetes      \_\_\_\_\_ Epilepsy      \_\_\_\_\_ Seizures
- \_\_\_\_\_ Asthma      \_\_\_\_\_ Headaches      \_\_\_\_\_ Stomachaches      \_\_\_\_\_ Bleeding tendency
- \_\_\_\_\_ Hearing difficulties      \_\_\_\_\_ Vision difficulties ( \_\_\_\_\_ glasses or \_\_\_\_\_ contacts)
- \_\_\_\_\_ Other \_\_\_\_\_