

**AUTHORIZATION FOR EMERGENCY CARE TO MINOR
& PERSONAL MEDICAL HISTORY
2011-12**

Student Name _____ **Birthdate** _____

(PLEASE PRINT LEGIBLY)

Child's Social Security # _____ **Male** _____ **Female** _____

Parents: Father _____ **Mother** _____

Child resides with _____ **Father** _____ **Mother** _____ **Both** _____ **Other** _____

Home Address: _____ **City** _____ **State** _____ **Zip** _____

Phone Numbers: Calling Post # _____

Home _____ Mom Work _____ Mom Cell _____

E-mail: _____ Dad Work _____ Dad Cell _____

In case of emergency illness or accident the child will be given first-aid and the parents will be notified. If the parents or the child's doctor can not be reached, the child will be taken to the emergency room of your choice. Community Christian Academy does not assume responsibility for the payment of hospital, doctor, or ambulance fees.

Doctor's Name _____ **Phone #** _____

Health Insurance Carrier _____ **Group #** _____

Address: _____ **Subscriber #** _____

Hospital Preference: (Check one) Western Baptist Hospital _____ Lourdes Hospital _____

I/We the undersigned, parent(s) or legal guardian of minor (name) _____ do hereby authorize any x-ray examination, anesthetic, dental, medical, or surgical diagnosis or treatment by any physician or dentist licensed by the Commonwealth of Kentucky and hospital service that may be rendered to said minor under the general, specific, or special consent of an acting agent of Community Christian Academy, the temporary custodian of the minor, whether such diagnosis or treatment is rendered in the office of the physician or dentist, or at a hospital licensed by the Commonwealth of Kentucky. I/We understand that this consent is given in advance of any specific diagnosis or treatment being required, but is given to encourage those persons who have temporary custody of the minor, and said physician or dentist to exercise his best judgment as to the requirements of such diagnosis of mental, dental, or surgical treatment.

Signature of Parent/Guardian _____
Date

Current Medications
1. _____
2. _____

Medication Allergies
1. _____
2. _____

Emergency Contacts (Other than parents)

1. _____ Relation _____ Phone _____

2. _____ Relation _____ Phone _____