Fall ☐16 ☐17 ☐18 ☐19 ☐20 ☐21 ☐22 ☐23 ☐24 ☐25 ☐26 ☐27 ☐28

(Click or "X" the box in front of digits to indicate school year, i.e., "X16" indicates the fall of 2016.)

AUTHORIZATION FOR EMERGENCY CARE TO MINOR & PERSONAL MEDICAL HISTORY

Student Name ____________________________________ **Birthdate** ________________

Child's Social Security # __________________ **Gender** ☐ Male ☐ Female

Parents: Father _______________________________ **Mother** _______________________________

Child resides with: ☐ Father ☐ Mother ☐ Both ☐ Other

If "other," please name: _______________________________

Home Address: _______________________________ **City** ________________ **State** ___ **Zip** _____

Phone Numbers: Calling Post # _________________ (number for our automated service to contact)

Home _________________ **Mom Work** _________________ **Mom Cell** _________________

Dad Work _________________ **Dad Cell** _________________

E-mail: ______________________________

Name/Address of Church: ____

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 cannot 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: (Please "X") ☐ **Western Baptist Hospital** ☐ **Lourdes Hospital**

I/We the undersigned, parent(s) or legal guardian of minor (______________________________) 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 & Individuals who can pick-up (Other than parents)

1. ______________________________ Relationship __________________ Phone __________________
2. ______________________________ Relationship __________________ Phone __________________
3. ______________________________ Relationship __________________ Phone __________________