EMERGENCY MEDICAL TREATMENT AUTHORIZATION

Child's Name: _____ Date: _____

Any chronic conditions, allergies or medications that could be important in case of sudden illness or injury:

_____

Physician: _____ Phone: _____

Address of Physician: _____

EMERGENCY MEDICAL TREATMENT AUTHORIZATION

I hereby give permission for the staff of Battlefield Christian Academy to provide simple first aid treatment to my child, _____, when necessary.

In the event of a more serious illness or injury, I give permission for my child to be transported to a hospital or other emergency medical facility to receive emergency treatment.

I also authorize ambulance/EMS to administer such treatment as is medically necessary, and I authorize licensed health practitioners working in the hospital or emergency medical facility to examine and provide emergency medical treatment to my child if warranted.

Parent/Guardian Name (Please Print):

First Name **Last Name**

Signature: _____ **Date:** _____