First Christian Academy Emergency Medical Release Form

GRADE ____________ **SEX**____________ **AGE** _____ **BIRTHDATE** ______________ **DATE** __________________________

Child's Full Name____

Allergies: ____

Medicines Routinely Taken: ____

Name of Custodial Parent(s) Legal Guardian(s): Email: ____

____ ____

Mother's Name **Cell phone (include area code)**

____ ____

Father's Name **Cell phone (include area code)**

Person(s) NOT AUTHORIZED to visit/pickup child**:** ____

Emergency Contact (if custodial parent/guardian cannot be reached):

____

Name **Relationship** **Phone Number**

____________________________ ____________________________ ____________________________

Parent's Signature **Relationship to Student** **Date**

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

If, ____________________________________, should become ill or injured at First Christian Academy, I understand that the facility will (1) contact me immediately or (2) contact the person(s) I have designated if I cannot be reached. Should the facility be unable to reach me and/or the person(s) designated, they are authorized to arrange for emergency medical treatment necessary to ensure the health and safety of my child. I will accept responsibility for payment of medical services rendered. I give full consent to transport by ambulance if the situation warrants it.

STATE OF FLORIDA, COUNTY OF PASCO

The above was acknowledged before me on ____________________, 20______

By ____________________________, who is personally known to me or who

Name of Affiant

produced ______________________________as identification

Type of Identification

Signed ____________________________________ Seal

Signature of Notary