CENTRAL CHRISTIAN ACADEMY

5503 N Hiawassee Rd Orlando, FL 32818 | 407-290-1609

FAMILY MEDICAL AUTHORIZATION

STUDENT(S) INFORMATION:

Name:____Gender:________Male_________Female

Age:_____________ Birthday:___/_____/______Social Security Number:__/__/________________

Father Name:_______________________________Work Phone__________________Cell_______________

Mother Name:______________________________Work Phone___________________Cell_______________

MEDICAL INFORMATION

Daily Medications: ____

Allergies____

Medical Insurance Company_______________________________Policy # ___________________________

Name of Doctor to be called_______________________________Phone # ___________________________

Name of Dentist to be called______________________________Phone # ___________________________

Name of Hospital Preferred: ____

LIST TWO PERSONS TO CONTACT IF PARENTS CANNOT BE REACHED:

Name_____________________________Relationship______________Phone Number: _________________

Name_____________________________Relationship______________Phone Number: _________________

IN THE EVENT OF AN EMERGENCY WE WILL ACCESS THE 911 EMERGENCY SYSTEMS. IF YOU WOULD LIKE TO GIVE THEM ADVANCE PERMISSION TO BEGIN TRANSPORT AND TREATMENT OF YOUR CHILD, PLEASE SIGN THE FOLLOWING STATEMENTS.

PERMISSION TO TRANSPORT STATEMENT

I do hereby state that I am the parent or guardian of the child named on this form. In order to expedite care of this child, I hereby give my permission for the responding emergency team to immediately initiate treatment and transport of this child to the preferred or appropriate medical facility, according to what they deem is indicated by the nature or extent of the injuries. I agree to be financially responsible for this child's treatment and transport. I will notify the school of any changes of this information.

Parent Print Name:

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Parent Signature:

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PERMISSION TO TREAT STATEMENT

I do hereby state that I am the parent or guardian of the child named on this form. In order to expedite care of this child, I give my permission for the appropriate medical personnel and staff to initiate treatment immediately upon arrival to the appropriate facility. I agree to be financially responsible for this child's treatment. I also request that I be notified of my child's condition and admission as soon as possible. If I am unable to be reached, I request that the admitting facility notify one of the other individuals listed above of my child's condition and admission.

Parent Print Name:

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Parent Signature:

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