Emergency Medical Authorization

Name of Student: _____

Birthdate: _____/_____/_____

In the event reasonable attempts to contact me _____ (parent/guardian) are unsuccessful, I (We), the undersigned parent/legal guardian of _____, do authorize any hospital, clinic, or licensed physician to treat my/our child and administer any x-ray, examination, anesthetic, or surgical diagnosis rendered under the general or special supervision of any member of the medical staff of the hospital, clinic, or office.

Our preferred physician is _____ whose phone # is _____. Our preferred dentist is _____ whose phone # is _____. Our preferred hospital is _____.

In the event the designated preferred practitioner is not available, we authorize in advance another licensed physician or dentist the authority and power to render care in his/her best judgment and the transfer of the child to any hospital reasonably accessible. It is also understood that every effort shall be made to contact the parent/legal guardian prior to rendering treatment to the patient, but that treatment will not be withheld if the parent/guardian cannot be contacted. Permission is also granted for the school to provide emergency treatment to my/our child prior to his/her admission to any medical facility. This consent shall be valid as long and as many years as my child attends Bethel Christian Academy until revoked by me in writing.

_____ Date _____

Signature of Parent/Guardian

Acknowledged before me this _____ day of _____ , 20 ____.

_____

Notary Public (SEAL)

My Commission Expires: _____/_____/_____

List of restrictions/physical impairments:

List of special medications taken by child: