Emergency Medical and Extended Day Authorization

Please provide as much information as possible as this is used in cases of emergency.

Last Name: _____ First Name: _____ Middle Initial: ____ Grade: __

Preferred Name: _____

Address: _____ City, State, Zip: _____

Home Phone: _____ Date of Birth: _____ Family's Primary Email: _____

Father (or Guardian) Information

Name: _____

Day Phone: _____

Employer Name: _____

Home Phone: _____ Cell: _____

Home Address: _____

City, State, Zip: _____

Preferred Email: _____

Mother (or Guardian) Information

Name: _____

Day Phone: _____

Employer Name: _____

Home Phone: _____ Cell: _____

Home Address: _____

City, State, Zip: _____

Preferred Email: _____

Since the care and treatment of the student is primarily the responsibility of the parent, every effort will be made to contact the parent first.

Please list all persons who can be contacted regarding student's care in the event a parent cannot be located.

Only those listed below will be permitted to pick up your child .

Place an (E) behind the name of any person authorized for Extended Day pick up ONLY.

Name _____ Relation _____ Cell # _____ Work #_____

Name _____ Relation _____ Cell # _____ Work #_____

Name _____ Relation _____ Cell # _____ Work #_____

Name _____ Relation _____ Cell # _____ Work #_____

Name _____ Relation _____ Cell # _____ Work #_____

List anyone who is **NOT PERMITTED** to visit/pick up your child from school:

_____ _____ _____

This Form is 2 Sided - Please Complete Both Sides

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HEALTH INFORMATION - Student Name_____

(Last) (First)

List any **health conditions** that your child has:_____

List any **medications** that your child takes:

At home: _____

At School:_____

List any **allergies** that your child has and what treatment is needed for reactions.

Medication Alllergies _____

Food Allergies _____

Environmental allergies_____

Insect/Bee Allergies _____

Has your child traveled outside the United States in the past year? _____ No _____ Yes If so,Where? _____

If yes, did you stay in a home or hotel/resort? (please circle)

Medical Release and Authorization - MUST BE COMPLETED

****This Release and Authorization applies to on-campus as well as school sponsored activities or field trips off campus.**

I hereby give consent for the following medical care providers and local hospital to be called:

Physician_____ Phone _____

Dentist_____ Phone _____

Medical Specialist_____ Phone _____

Local Hospital_____ Phone _____

In the event reasonable attempts to reach the undersigned have been unsuccessful, we hereby give consent for 1. the administration of any treatment deemed necessary by above named doctors, or in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and 2. the transfer of the child to any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for the surgery, are obtained prior to the performance of such surgery.

The undersigned hereby give Bethany School, the Society of the Transfiguration, their employees, and their agents full authority and permission to take whatever action they feel is reasonably warranted under the circumstances and to act as agent of the undersigned student, parent, or guardian, as the case may be, regarding the student's health and safety including permission to render medical treatment, the giving of medication, and consent to any examinations, x-rays, anesthetic, medical or surgical diagnosis, treatment, or hospital care, if and when deemed necessary, all in the physician's reasonable discretion.

The undersigned hereby release Bethany School, the Society of the Transfiguration, their employees, and their agents from all liability related to such decisions or actions as may be taken in connection therewith.

Date_____ Signature of Parent/Guardian_____

Date_____ Signature of Parent/Guardian_____

This Form is 2 Sided - Please Complete Both Sides