



7820 Thomas Jefferson Parkway
Palmyra, VA 22963
Office (434) 808-2447
www.effortchristianschools.com

EMERGENCY MEDICAL AUTHORIZATION

Student First Name Student Last Name Student Date of Birth

Address City State Zip Telephone

Purpose – To enable parents/guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority when parents/guardians cannot be reached.

PART 1 OR 2 MUST BE COMPLETED
Part 1 – To Grant Consent

Parent/Guardian Relationship / Phone (home/cell)

Address (if different) Employer / Work Phone

Spouse’s Name Spouse’s Employer / Phone

IN THE EVENT I CANNOT BE REACHED, THE SCHOOL HAS MY PERMISSION TO RELEASE MY CHILD TO THE NAMES LISTED BELOW ONLY. A PICTURE I.D. MAY BE REQUIRED BEFORE THE STUDENT WILL BE RELEASED! NO EXCEPTIONS!

- 1. _____ Phone: _____
- 2. _____ Phone: _____
- 3. _____ Phone: _____
- 4. _____ Phone: _____



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**FACTS CONCERNING THE CHILD'S HISTORY
TO WHICH A PHYSICIAN SHOULD BE ALERTED:**

Glasses/contacts ____ Hearing Aid ____ Diabetes ____ Seizures ____

Allergies _____

Physical Impairments _____

Medication taken _____

Medications to be given by school _____

Other (or explanations to above) _____

Primary Physician _____ Phone _____

Primary Dentist _____ Phone _____

Alternate Physician/Dentist _____ Phone _____

Health Insurance _____ Group# _____ Policy# _____

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

Parent/Guardian Signature _____ Date _____

Part 2 – Refusal to Consent

I do **NOT** give my consent for emergency medical treatment for my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take no action or:

Parent/Guardian Signature _____ Date _____