

Authorization to Consent to Medical Treatment

(PLEASE PRINT)

I (We) _____ and _____ are the parents/legal guardian, with legal custody of _____ (child's name) who is _____ (age), and resides with us at _____ (full address) and who attends Grove City Christian School, give our permission for a licensed doctor, physician, or emergency treatment center selected by the school/coach/representative to administer the necessary attention and aid **IMMEDIATELY** to our child should he/she become injured or sick during all sporting events: practices, games, tournaments, and travel to and from, and to do so without having to wait until we are contacted. We consent to any x-rays, examination, anesthetic, medical or surgical diagnosis, treatment and hospital care deemed necessary.

We understand the school/coach/representative will endeavor to reach us should the nature of the injury or illness warrant it. However, we will not hold any of the school personnel responsible if efforts to contact me (us) are unsuccessful. During this time we can be reached at:

Home: (address listed above); Home Phone: _____.

Father's Business Phone: _____

Business address: _____

Mother's Business Phone: _____

Business address: _____

Father/guardian signature: _____ Date: _____

Mother/guardian signature: _____ Date: _____

Nearest relative to contact if parents cannot be reached:

Name: _____, Relationship: _____

Phone number: _____

MEDICAL INFORMATION

Child's Doctor: _____ Phone: _____

Parent's Doctor: _____ Phone: _____

Medical Insurance Company: _____

Policy Number: _____

Allergies to medicines or other allergies: _____

Child is presently taking the following medication: _____

For the following condition: _____

Additional Information: