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: