Authorization to Consent to Medical Treatment

I (We) _____ and _____ are the

Parent(s)/legal guardian(s), with legal custody of

Child's Name	Birth date	Child's Name	Birth date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

who reside with us at _____
and who attend Howardsville Christian School, give our permission for a licensed doctor, physician or emergency treatment center selected by the school, coach or other representative, to administer the necessary attention and aid IMMEDIATELY to our child should he/she become injured or sick during any school sponsored event, and to do so without having to wait until we are contacted. We consent to any X-rays, examination, anesthetic, medical or surgical diagnoses, 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 the time we can be reached at:

Home phone _____ Cell Phone _____ Other _____
_____ Date Father/Guardian signature _____
_____ Date Mother/Guardian signature _____

Doctor _____ Phone _____
Medical Insurance Company _____Policy # _____
Allergies to medicines or other allergies
_____
_____
Child is presently taking the following medication
_____
_____
For the following condition(s)
_____
_____

Additional Information
_____
_____