2023-2024

EMERGENCY MEDICAL AUTHORIZATION FORM

Salem Christian Academy, LLC

Allergy Alert ☐

Student Name: _____ Grade: _____
(please print) Last First

Address: _____ Birth Date: _____ Male ☐
MM/DD/YYYY

City/Zip Code: _____ Student resides with: _____ Female ☐

PARENT/GUARDIAN & EMERGENCY CONTACT INFORMATION

Relationship:	Name:	Home Phone:	Cell Phone:	Work Phone:	Can Pick Up:
Parent/Guardian					☐
Parent/Guardian					☐
					☐
					☐
					☐

Please indicate if your child has any of the following:

1. Allergies:* _____

***CHOOSE ONE** - If your child has allergies, should he/she eat lunch: ☐ at the class table - or - ☐ at the table for students w/ allergies?

2. Medications:** _____

3. Inhalers:** _____

4. Other medical concerns or conditions: _____

**Use of any medication at school requires the appropriate documentation to be completed & on file with the school office. Any listed medication & completed Student Medication Form MUST be turned in to the office prior to the 1st day of school. *Student Medication Forms can be found at SalemChristianAcademy.com*

PART I OR II MUST BE COMPLETED

PART I: TO GRANT CONSENT

I Hereby Grant Consent for the following medical care providers and local hospital to be called:

Doctor: _____ Phone: _____

Dentist: _____ Phone: _____

Medical Specialist: _____ Phone: _____

Local Hospital/Emergency Room Phone: _____

_____ _____
Signature of Parent/Guardian Date

PART II: REFUSAL TO CONSENT

I Do Not Grant Consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take the following action:

_____

_____

_____

_____ _____
Signature of Parent/Guardian Date