

Covenant HomeSchool Resource Center

Office location: 1117 E. Devonshire Ave, Phoenix, AZ 85014

Phone: 602-277-3497 E-mail: info@chsrc.org Website: www.chsrc.org

EMERGENCY MEDICAL FORM

Student Name: _____ Date of Birth: _____ Grade: _____
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PART I-Residential Parent/Guardian Information: Identify the names of the adults that we should contact to release your child to if your child becomes ill at Covenant or needs to be picked up for any reason.

Mother's Name: _____ Daytime Phone: _____ Cell Phone: _____
Father's Name: _____ Daytime Phone: _____ Cell Phone: _____
Mother's Email Address: _____ Father's Email Address: _____
Other's Name: _____ Daytime Phone: _____ Cell Phone: _____
Name of Relative or Child Care Provider: _____ Relationship: _____
Address: _____ Phone: _____

PART II – TO GRANT CONSENT:

PURPOSE: To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under Covenant's authority, when parents or guardians cannot be reached.

Doctor: _____ Phone: _____
Dentist: _____ Phone: _____
Medical Specialist: _____ Phone: _____
Local Hospital: _____ Phone: _____

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 designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to any hospital reasonably accessible. 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.

List below facts concerning the child's medical history including allergies, medication taken, and any physical impairments to which a physician should be alerted:

Signature of Parent/Guardian: _____ Date: _____
Address: _____

PART III – REFUSAL TO CONSENT: I do NOT give consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish Covenant to take the following actions:

Signature of Parent/Guardian: _____ Date: _____
Address: _____

For Office use only:

Family file _____ Copy to family _____ Copy to teachers _____