Medical Authorization for Treatment of Minors

14510 Spriggs Road
Woodbridge, VA 22193
703.680.6629
Fax 703.670.3308

This form must be completed yearly in its entirety for each student.
This form is for authorization of treatment in the event of an emergency while away from the school campus (i.e. Field trips, Sporting events, etc.)

STUDENT'S FULL NAME / GRADE ______________________ SOCIAL SECURITY NUMBER ____-____-____ DATE OF BIRTH *(MM/DD/YYYY)* ____/____/____

PERMISSION

"I, ______________________ GIVE PERMISSION TO HERITAGE CHRISTIAN SCHOOL TO
PARENT/LEGAL GUARDIAN (PRINT)
AUTHORIZE EMERGENCY MEDICAL TREATMENT FOR THE CHILD IDENTIFIED ABOVE."

PARENT/LEGAL GUARDIAN (SIGNATURE) ______________________ DATE ______________

CONTACTS

CHILD'S ADDRESS	CITY	STATE	ZIP CODE	HOME PHONE

NAME OF PARENT/GUARDIAN #1	WORK PHONE	CELL PHONE	OTHER PHONE
NAME OF PARENT/GUARDIAN #2	WORK PHONE	CELL PHONE	OTHER PHONE
NAME OF PARENT/GUARDIAN #3	WORK PHONE	CELL PHONE	OTHER PHONE
NAME OF ALTERNATE CONTACT	WORK PHONE	CELL PHONE	OTHER PHONE
NAME OF PHYSICIAN		OFFICE PHONE	ALT PHONE

MEDICAL DATA

PLEASE LIST ALL OF THE FOLLOWING:

Date of last DPT/Tetanus ______________________

Known allergies to medications ______________________

Known illnesses (asthma, epilepsy, etc.) ______________________

Routine medications taken ______________________

INSURANCE

NAME OF INSURANCE COMPANY ______________________ POLICY NUMBER ______________

SUBSCRIBER'S NAME ______________________ EMPLOYER ______________

It is our policy to record all medical incidents or accidents that occur while your child is in our care. We will send home a detailed report for your signature following every accident that occurs.

Revised 1.8.15