2021-2022

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