

# TRI-CITIES CHRISTIAN SCHOOLS EMERGENCY MEDICAL AUTHORIZATION

Name of Child: \_\_\_\_\_ Grade: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ SSN: \_\_\_\_\_  
 Name of Parent(s) or Guardian: \_\_\_\_\_  
 Home Address: \_\_\_\_\_ City: \_\_\_\_\_  
 State, Zip: \_\_\_\_\_ Phone: \_\_\_\_\_ Email: \_\_\_\_\_  
 Siblings: \_\_\_\_\_

Mother's Place of Employment: \_\_\_\_\_  
 Work Phone Number: \_\_\_\_\_ Pager or Cell: \_\_\_\_\_  
 Work Schedule: \_\_\_\_\_ Email: \_\_\_\_\_

Father's place of Employment: \_\_\_\_\_  
 Work Phone Number: \_\_\_\_\_ Pager or Cell: \_\_\_\_\_  
 Work Schedule: \_\_\_\_\_ Email: \_\_\_\_\_

### Emergency contacts and individuals authorized to pick up your child:

1. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Phone: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_
2. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Phone: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_
3. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Phone: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_
4. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Phone: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_
5. Other: \_\_\_\_\_

### Insurance Information: \_\_\_\_\_ Hospital Preference: \_\_\_\_\_

The Parent(s) Guardian authorizes Tri-Cities Schools, Inc. to obtain immediate medical care and consents to the hospitalization of, the performance of necessary diagnostic test upon, the use of surgery on, and/or the administration of drugs to, his/her child or ward if any emergency occurs when he/she cannot be located immediately. It is also understood that this agreement covers only those situations which are true emergencies and only when he/she cannot be reached. Otherwise he/she expects to be notified immediately.

1. I/we will be responsible for payment of medical care expenses.
2. Medical treatment costs are covered by:
  - A. Name of Insurance Company: \_\_\_\_\_ Policy Number: \_\_\_\_\_
  - B. Medical Coverage Number: \_\_\_\_\_ Name of Subscriber: \_\_\_\_\_
  - C. No Insurance: \_\_\_\_\_ (please initial)

Child's physician or clinic attended: \_\_\_\_\_

Physician or clinic telephone number: \_\_\_\_\_

Food or Medicine Allergies: \_\_\_\_\_

Other medical conditions we should know: \_\_\_\_\_

List any medication that your child takes on a regular basis and the time that it is normally given: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_