



Calvary Baptist Day School Student Medical Consent & Update

(Homeroom) Teacher's Name _____ Grade _____

Student's Name _____ School Year 20__ - 20__

In the event that your child becomes seriously ill or injured while at school, the school will take action as outlined below:

1. Appropriate first aid will be administered immediately when the situation calls for it.
2. In extreme emergencies, your child will be taken immediately to the hospital emergency room by ambulance or private vehicle and you will be contacted and advised of the situation. In most cases, however, efforts will be made to **contact you first** and to seek your advice concerning the action to be taken by the school.
3. In the event that you cannot be located or in extreme emergencies, the school will decide whether immediate medical treatment is needed and will act accordingly.

In order to assure that proper medical treatment can be obtained under the conditions described in #3 above, we request that you complete the form below, giving the school permission to obtain medical treatment for your child and certifying that you will accept the financial responsibility for payment of any ambulance, hospital and/or physicians' bills and charges. **Calvary Baptist Day School does not provide student accident insurance.** Parents are expected to provide medical/accident insurance for their child/children.

I, the undersigned, give permission to Calvary Baptist Day School, its teachers, staff or persons working in its behalf, to act in my absence in emergency situations to obtain medical treatment for my child.

_____ I agree to accept full responsibility for the payment of all ambulance, hospital and physicians' bills and charges for any services rendered.

_____ My child's immunizations are current. _____ My child is free of communicable diseases.

Life-threatening allergies: _____

Maintenance medications my child is taking: _____

Signature of Parent

Phone: Home _____ Dad's Work _____ Dad's cell _____

Mom's Work _____ Mom's cell _____

Family Doctor _____ Phone _____

Hospital Preference _____

Insurance Company _____

Policy Number _____

