

**Consent for Emergency Medical Treatment and Allergy Information  
2024-2025**

**Date** \_\_\_\_\_

**Child's Name** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Special Medical Information You Want Us To Know About:** \_\_\_\_\_

**Allergies:** \_\_\_\_\_

I, Parent/Legal Guardian of \_\_\_\_\_, read and understand the Emergency/First Aid Procedures as stated in the Parent Handbook, and consent to the procedures described.

I authorize the Principal of Beacon Christian Academy, or such staff members or licensed physicians as may from time to time be designated, to perform first aid procedures in the event of injury or illness of my child.

In case of a major accident, injury or illness requiring immediate medical or surgical care, I further authorize said persons to stabilize the child and to act on my behalf, provided that they first make such effort as the nature of the emergency permits to notify me, or if I am unavailable, the following person can be contacted:

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Name (Other than Parent/Legal Guardian)	Relationship to Child	Phone #
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Whom I hereby also authorize to act on my behalf, of the situation and obtain my (or his/her) preferences. If such efforts to contact me or my representative designated above are unsuccessful, I authorize the Principal and/or Staff members of Beacon Christian Academy to arrange to transport my child to the nearest local hospital Emergency Center and to secure for my child any medical treatment deemed necessary or appropriate by any licensed practitioner. I also agree to reimburse those persons acting hereunder for any cost or expenses which are incurred on my behalf or on behalf of the child with regard to any medical attention sought for the child.

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

Medical Insurance Carrier: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Pediatrician's Name & Phone Number: \_\_\_\_\_

City/State: \_\_\_\_\_