
First Initial of Last Name Grade

GRACE COMMUNITY SCHOOL
Authorization for Off-Campus Emergency Treatment (PLEASE PRINT)

Student Name: _____ Birth Date: ___/___/___ Grade: _____

My child is subject to the following physical limitations and/or drug allergies noted below:

Address: _____

City: _____ Zip: _____

Home Phone #: (____) _____ Alt Phone #: (____) _____

Email 1: _____ Email 2: _____

Father's Name: _____ Employer: _____

Day Phone #: (____) _____ Cell Phone #: (____) _____

Mother's Name: _____ Employer: _____

Day Phone #: (____) _____ Cell Phone #: (____) _____

Mother/Legal Guardian Signature: _____ Date: _____

Father/Legal Guardian Signature: _____ Date: _____

Contact(1): _____ Relationship: _____

Phone: (____) _____

Contact(2): _____ Relationship: _____

Phone: (____) _____

Contact(3): _____ Relationship: _____

Phone: (____) _____

Last Name: _____

Authorization for Off-Campus Emergency Treatment
(PLEASE PRINT)

If unable to reach either parent/guardian in any emergencies, Grace Community School is authorized to contact, and if necessary, release our child to one of the following designated persons. (Parents, please note: Children may ONLY be released to contacts listed.)

Primary Doctor: _____ Hospital/Clinic: _____

Phone:(_____) _____

Alternate Doctor: _____ Hospital/Clinic: _____

Phone:(_____) _____

Insurance Company: _____ Policy No.: _____

I the undersigned, being the legal guardian (having legal custody) of _____, a minor, hereby authorize Grace Community School and/or its designated leaders, the person(s) into whose care the aforementioned minor pupil has been entrusted, in the event of an emergency, and, if contact cannot be made with myself, under section 25.8 of the California Civil Code, to consent to any X-ray examination, anesthetic, medical or surgical diagnosis, treatment, and/or hospital care which is deemed advisable by and to be rendered by or under the supervision of a physician licensed under the provisions of the medical practice act in which state and/or the State of California; and to consent to any X-ray examination, anesthetic, dental surgical diagnosis or treatment and/or hospital care to be rendered to said minor by any dentist licensed in which state and/or by the State of California.

It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required, but given to provide authority and power on the part of the aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care which the aforementioned physician or dentist, in the exercise of his best judgment, may deem advisable. I accept full responsibility for the cost of any such examination, treatment, ambulance ride, or hospitalization.

I understand that Grace Community School authorities will notify me or my designated representative if my child is ill or injured. If no one can be contacted, I understand that it is the policy of the school to send the injured child in an ambulance to the nearest emergency hospital unless instructions to the contrary are on file in the school office.

In consideration of Grace Community School providing my child off campus activities and transportation thereto, I do hereby release Grace Community School, its officers, employees, agents, coaches, leaders and members of the Board of Elders of GCS from all claims and causes of action by reason of any injury which may be sustained as a result of these activities, whether on the church premises, at the activity location, or during transportation to or from these activities.

My child is subject to the physical limitations and/or drug allergies noted on the opposite side.

This authorization shall remain in effect for the entire school year, unless revoked in writing by the parent and/or legal guardian and delivered to Grace Community School in writing.

Parent/Legal Guardian Signature: _____ Date: _____