

Emergency Information and Medical Release Form



Date: _____

Mother/Guardian's Full Name: _____

Father/Guardian's Full Name: _____

Address: _____

Mother's Phone #: (home) _____ (cell) _____ (work) _____

Father's Phone #: (home) _____ (cell) _____ (work) _____

In the chart below, please list all known medical conditions, **including food allergies and/or medicine allergies**. In addition, please list any and all over-the-counter and/or prescription medications taken regularly. **If your child has no known allergies, no medical conditions, or requires no medications please write "None" or "None Known" in the space provided.** There is additional space below the chart for comments or explanations regarding this information.

Child's Name	Pertinent Medical Information

Additional Comments/Instructions:

In an emergency please contact: _____ Phone: _____

Relationship to child(ren): _____

If this contact is unavailable, please contact: _____ Phone: _____

Relationship to child(ren): _____

Physician's Name: _____ Dentist's Name: _____
Address: _____ Address: _____

Phone: _____ Phone: _____

Primary Insurance Provider: _____
Phone: _____
Billing Address: _____
Policy Holder's
Name: _____
Address: _____
Relationship to Child(ren): _____
ID#: _____ Policy#: _____

Secondary Insurance Provider: _____
Phone: _____
Billing Address: _____
Policy Holder's
Name: _____
Address: _____
Relationship to Child(ren): _____
ID#: _____ Policy#: _____

Statement of Consent: *(To be signed in the presence of a legalized notary public)*

In the event of an emergency or non-emergency requiring medical treatment, I, _____, hereby grant permission to Pinnacle Classical Academy to make appropriate decisions regarding any and all medical and/or dental attention to be administered to my child/children, in the event of an accidental injury or illness, until such time as I can be contacted. This permission includes, but is not limited to, administration of first aid, the use of ambulance, and the administration of anesthesia and/or surgery, under the recommendation of qualified medical personnel.

Signature: _____ Date: _____

Notarization:

On this _____ day of _____, _____, _____ personally appeared
Month Year Name of Parent/Guardian
before me in _____ County (in the state of _____) and, in my presence, signed
this medical release and consent form.

Name of Notary Official: _____

Signature: _____

Commission Expires: _____