Delaware Christian School
Emergency Contact Information & Emergency Medical Authorization

Revised 09/05/13

Please complete one form per student.

Grade: _____ Date of Birth _____

First/Middle Name: _____ Last Name:_____

Address:_____

Parent's/Guardian's Name:_____ Relationship:_____

Address:_____

Email Adress:_____

Home Phone #:_____ Cell Phone #:_____

Work Phone #: _____

Parent's/Guardian's Name:_____ Relationship:_____

Address:_____

Email Adress:_____

Home Phone #:_____ Cell Phone #:_____

Work Phone #: _____

It is mandatory that two alternate contacts are listed. They must be a person other than you or your spouse.

Alternative Emergency Contact: _____

Relationship: _____

Home Phone #:_____ Cell Phone #:_____

Work Phone #: _____

Alternative Emergency Contact: _____

Relationship: _____

Home Phone #: _____ Cell Phone #:_____

Work Phone #: _____

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Family Doctor's Name: _____ Phone#:_____

Family Dentist's Name:_____ Phone#:_____

Medical Conditions:_____

_____

Current Medications: _____

_____

Please check all that apply:

__Diabetes __Asthma __Epilepsy __Heart Condition __Hearing Loss __Vision Loss

__Allergies: __Bee Stings __Foods (list) _____

__Medications (list)_____

Any physical limitations/Explain: _____

_____

Insurance Information:

Policy Holder:_____ Policy/Insurance Name: _____

Policy #:_____ Group #:_____ Member ID:_____

PART 1 OR 2 MUST BE COMPLETED

Part 1 – Grant Consent

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) any treatment deemed necessary by above named physician or dentist; in the event the designated preferred practitioner is not available by another licensed physician or dentist; and (2) the transfer of the student to the nearest available hospital. The authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists concurring in the necessity for such surgery.

Date _____

Signature of Parent/Guardian _____

Part 2 – Refusal to Consent

I do NOT give my consent for medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school take the following action:

_____

_____

_____

_____

Date _____

Signature of Parent/Guardian _____