E M E R G E N C Y / M E D I C A L   I N F O R M A T I O N

Jefferson County Christian School
2501 Commercial Avenue
Mingo Junction   Ohio 43938   (740) 535-1337

Student's Name____ Grade_____________________
Address____
Telephone Number____ Date of Birth ______________________

Father/Guardian's Name______________________ Mother/Guardian's ______________________________
Father/Guardian's Employer____________________ Mother/Guardian's Employer_____________________
Employer's Address__________________________ Employer's Address____________________________
City______________________ State____________ City___________________________ State__________
Work Phone # _______________________________ Work Phone # _________________________________

Father/Guardian Cell Phone ______________________ Mother/Guardian Cell Phone ______________________

People to be contacted and the release of my child to their care in the event of an emergency or sickness if the parent cannot be contacted:

Name____________________________________ Name_____________________________________
Address__________________________________ Address___________________________________
City______________________ State____________ City___________________________ State__________
Phone # _________________________________ Phone #___________________________________
Relationship to child_______________________ Relationship to child___________________________

Physician's Name___________________________ Dentist's Name_______________________________
Address_________________________________ Address ___________________________________
Phone #_________________________________ Phone # ___________________________________

Facts concerning the child's medical history (include allergies, medications being taken, physical impairments, or any other information to which a physician should be alerted): ____
____
____

I understand that this form will stay on file at Jefferson County Christian School during the current school year. By signing in one of the two spaces below, I am stating that everything in this form is correct and any changes that are made must be in writing. A new emergency form must be completed in order for a student to begin each new school year.

Please sign in one of the two spaces provided:

PERMISSION TO TRANSPORT AND OBTAIN TREATMENT

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my permission for: (1) the administration of any needed treatment deemed necessary by the named physicians, or in the event the designated practitioner is not available, by another licensed physician or dentist; and (2) the transfer of my child to (preferred hospital) ___________________________
or any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained before surgery is performed.

Signed ____ Date____________________

REFUSAL TO GRANT PERMISSION TO TRANSPORT AND OBTAIN TREATMENT

I DO NOT give permission to transport my child for emergency medical or dental care. In the event of an illness or injury which requires emergency medical or dental treatment, I wish Jefferson County Christian School to take the following actions:____

Signed____ Date____________________