

# Harvest Time Christian School

## *Authorization for Emergency Medical Treatment*

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If my child, \_\_\_\_\_, should become ill or injured at HARVEST TIME CHRISTIAN SCHOOL, I understand that the facility will:

- contact me immediately and/or
- contact the person(s) I have designated if I cannot be contacted

Should the facility be unable to reach me and/or the person(s) I have designated, Harvest Time Christian School is authorized to contact my child's physician and/or arrange for immediate emergency treatment.

The physician and/or medical facility are authorized to administer emergency medical treatment necessary to ensure the health and safety of my child.

I will accept responsibility for payment of medical services rendered.

\_\_\_\_\_  
(Date) (Signature of Parent/Guardian - Father)

\_\_\_\_\_  
(Date) (Signature of Parent/Guardian - Mother)

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Person(s) designated if I am unable to be reached:

\_\_\_\_\_  
(Name) (Phone)

\_\_\_\_\_  
(Name) (Phone)

\_\_\_\_\_  
(Name) (Phone)

Medical Alert Information: \_\_\_\_\_

Preferred Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Preferred Hospital: \_\_\_\_\_

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Expiration Date: \_\_\_\_\_

Notary of Public (seal)

On this \_\_\_\_\_ day of \_\_\_\_\_

Year \_\_\_\_\_

*NOTE: Two (2) originally signed copies of this form must be on file in our office.*