2023-2024 Authorization for Medical Treatment

Student Last Name: _____ First: _____ M.I. _____
Date of Birth: _____ Age: _____

Parent/Guardian #1 Name: _____
Home Address: _____
Phone Number(s) Cell: _____ Work: _____ Home: _____

Parent/Guardian #2 Name (if applicable): _____
Home Address: _____
Phone Number(s) Cell: _____ Work: _____ Home: _____

Emergency Contact (other than parent): _____
Home Address: _____
Phone Number(s) Cell: _____ Work: _____Home: _____

Emergency Medical Treatment Authorization

I/we, being the parent(s)/legal guardian(s) of the above-named child, hereby allow any member of the faculty, staff, or administration of Chesapeake Bay Academy to authorize the emergency medical treatment of my/our child at any hospital, clinic, or other certified medical facility, or by licensed physician, paramedic, or other licensed medical personnel. The decision to submit the above-named minor child to such emergency medical treatment is at the discretion of the employees of Chesapeake Bay Academy. Furthermore, such discretion is to be exercised only when I/we or either of us cannot be reached at the above telephone numbers unless**,** at the discretion of the member of the faculty, staff, or administration, the situation is so serious as to warrant immediate medical attention. I/we understand that this assignment is made for the safety and benefit of my/our child and agree to hold harmless Chesapeake Bay Academy and its employees (1) for the negligence or wrongdoing of any hospital, clinic, or other certified medical facility, or any licensed physician, paramedic or other licensed medical personnel who may render care or treatment to my/our child; (2) for the selection of any such medical practitioner or facility; or (3) for any emergency treatment rendered by the employees of Chesapeake Bay Academy.

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

ALLERGIES: _____ DATE OF LAST TETANUS: _____

CURRENT MEDICATIONS: (List all prescription, emergency, over the counter, and herbal medications your child takes regularly.) _____

HEALTH HISTORY (Diabetes, Heart condition, Stroke, etc.): _____
_____

Preferred Hospital (IF conditions allow choice): _____
Health Insurance Company: _____ ID # _____