



EMERGENCY MEDICAL CONSENT FORM
Permission for medical care in parental absence.

_____ Brookhollow Christian Academy _____ has my permission to obtain
emergency medical treatment for my child, _____
when I cannot be reached or if a delay in reaching my child would be dangerous for him/her.

Mother/Guardian's Name _____
Home Phone _____ Cell Phone _____
E-mail Address: _____

Father/Guardian's Name _____
Home Phone _____ Cell Phone _____
E-mail Address: _____

Person to be contacted in emergency if parents are not available:

Name _____
Relationship _____
Home Phone _____ Cell Phone _____
E-mail Address: _____

Person to be contacted in emergency if parents are not available:

Name _____
Relationship _____
Home Phone _____ Cell Phone _____
E-mail Address: _____

Preferred hospital/treatment center _____

My child is taking the following medications

My child has the following allergies:

I understand that I assume all financial responsibility for any treatment or injuries sustained
by my child while he/she is in child care.

Signature of Parent or Guardian Date

Signature of Parent or Guardian Date