MEDICAL AUTHORIZATION

I authorize the staff of Soaring Eagles Christian Academy to treat, discipline, restrain, and, if necessary, obtain medical care for my child, _____ including, but not limited to, any emergency surgical procedure or hospitalization if it should become necessary where ever my child may be located.

This permission is given for and in the consideration of the staff of Soaring Eagles Christian Academy, during the school year, summer camp, in-service days and vacation days during normal operating hours and for all field trips involving extended times for which I have allowed my child to participate.

Parent's Name: _____Home Phone:_____

Father's Cell Phone #:_____Mother's Cell Phone #:_____

Address: _____
Street *City* *State* *Zip*

Please complete the following information:

In case of an emergency and a parent or guardian cannot be reached, please contact:
_____

Day Phone: _____ Evening Phone:_____

Insurance Carrier:_____

Policy Number:_____

List of know allergies:_____

Special Medication:_____

Special Treatment:_____

Any other problems or diseases: _____
_____

I understand any changes made to my family's insurance must be reported to Soaring Eagles Christian Academy by me.

Parent or Guardian Signature:_____

Date:_____