ATHENAEUM LEARNING CENTER
Learning for the 21st Century

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Emergency Medical Permission Form

The purpose of this form is to enable parents/guardians to authorize the provisions of emergency treatment for children who become ill or injured while under the care of the Athenaeum Learning Center, when the child's parents/guardians can not be reached. This form will authorize the release of medical information to school officials/employees who have responsibility for the students while the student is at school, at school events, or is being transported by the school. This form will accompany the student any time they leave the premises while under school care, and will be used as a medical release only until a parent or guardian can be contacted.

Child's Name: _____ DOB: _____

Parent/Guardian #1 Name: _____ Relationship: _____
Address: _____ State: _____ Zip: _____
Daytime Phone: _____ Alt. Phone: _____
Employer: _____ Work Phone: _____

Parent/Guardian #2 Name: _____ Relationship: _____
Address: _____ State: _____ Zip: _____
Daytime Phone: _____ Alt. Phone: _____
Employer: _____ Work Phone: _____

Is there a legal or custody order that applies to this child? ☐ Yes ☐ No (If yes, please attach details)

Emergency Contacts: (will be called in the order given, if parents/guardian can not be reached)
1. Name: _____ Relationship: _____ Phone: _____
2. Name: _____ Relationship: _____ Phone: _____
3. Name: _____ Relationship: _____ Phone: _____

Emergency Care Information:
Preferred Physician: _____ Phone: _____
Preferred Dentist: _____ Phone: _____
Preferred Hospital: _____ Phone: _____

Insurance Carrier: _____

Identification Number: _____

 Student name: _____ Birthdate: _____

Known medical conditions, special health considerations, and allergies: _____
_____
_____
_____
_____
_____
_____

In the event that reasonable attempts to contact me have been unsuccessful, I hereby give my consent for the administration of any treatment deemed necessary by the above mentioned doctors, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and the transfer of the child to 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 prior to performance of such surgery. In addition to the aforementioned information, I give my permission for any and all medical information to be shared with all school personnel that interact with my child while I remain unreachable.

Parent/Guardian Name: _____

Signature: _____ Date: _____