

Pike County Christian Academy

Medical Release Form

Date _____

Child's name _____

Telephone numbers where parent(s) or guardian(s) may be reached during time child is in school.

Mother _____ Father _____

Other _____

Medical Treatment

Child's doctor _____

Office phone _____

Office address _____

Child's dentist _____

Office phone _____

Office address _____

Should my child, _____, become ill or suffer an accident of any character while he/she is in the care of Pike County Christian Academy, the staff shall attempt to contact me immediately. Pike County Christian Academy and/or its designated staff shall be authorized to secure and to consent to such medical attention, treatment, and services for my child deemed necessary.

Any qualified person providing such required medical attention, treatment, and services for my child may accept such consent as if given by me in person. I agree to assume responsibility for payment of all medical costs incurred.

Signature _____

Persons other than the parent(s) or guardian(s) to contact if your child becomes ill or injured during the time he or she is at Pike County Christian Academy and the parent(s) or guardian(s) cannot be reached:

Name _____ Phone _____

Relationship _____ Address _____