CALVARY CHAPEL
CHRISTIAN SCHOOL

CONSENT FOR MEDICAL TREATMENT

Student Name _____ Date of Birth _____

Parent/Guardian agrees the provider may consult with the child's nurse or attending physician in regards to child's health as needed. In the event that we should have questions regarding the health of the enrolling/enrolled child we may contact one, or more, of the following sources for information.

- Hospital of choice and phone number _____
- Local Health Entity

Dr. Name:	Address:	Telephone #:

In an emergency, I, _____, (Parent/Guardian), give my authorization to, _____, (Provider's name) and any local physician, dentist or hospital to provide medical care and/or transport my child at my expense.

Medical Plan:	Policy #:	Telephone #:

Print Name _____ Signature _____

Date _____