Emergency Information
One per Student

_____ _____ _____
STUDENT'S FULL NAME CURRENT GRADE DATE OF BIRTH

Emergency Contacts
(other than parents/grandparents/guardians specified in Application)

Check box to also add to Pickup List

☐ _____
NAME RELATIONSHIP TO APPLICANT PHONE

☐ _____
NAME RELATIONSHIP TO APPLICANT PHONE

☐ _____
NAME RELATIONSHIP TO APPLICANT PHONE

My signature to this document is authorization for my child(ren) to participate in all school activities including, but not limited to, field trips, sports, and physical education. I absolve The Frankfort Christian Academy, its agents, servants, and employees from any and all liability to me or my child(ren) while my child(ren) attend(s) The Frankfort Christian Academy or engage in school sponsored activities.

In the event that my child(ren) is/are taken ill or is/are injured while under school authority, my signature to this document is authorization for school personnel to proceed as follows:

1. If the designated family doctor cannot be reached, the school is authorized to contact a properly licensed practicing physican of its choice and such physician is authorized to proceed to provide such medical and/or surgical services as may be needed. The Headmaster is hereby authorized, appointed, and empowered to furnish on the parent's behalf such written or oral authorizations as may be required under the circumstances herein described.

   _____
   FAMILY PHYSICIAN PHONE

   _____
   PREFERRED HOSPITAL

2. In the event a given illness or injury is judged life threatening by a school official; the school is authorized to first secure emergency medical services and then proceed to contact parent(s).

3. Medical Insurance Co. _____ Policy No. _____

4. School personnel are released from any liability, which might arise from granting authorization under this section.

Parents are responsible for bringing students' medications to the front office.

Facts concerning the child's medical history, <u>including allergies</u>, medication being taken, and any physical impairments to which a physician should be alerted:

_____

_____

_____

Additional people to add to Pickup List (if boxes selected earlier in application, they do not need to be added again):

_____
NAME RELATIONSHIP TO APPLICANT PHONE

_____
NAME RELATIONSHIP TO APPLICANT PHONE

_____ _____
PARENT/GUARDIAN SIGNATURE DATE