Medical Authorization

Please complete one form, both sides, yearly for each student.

14510 Spriggs Road
Woodbridge, VA 22193
703.680.6629
Fax 703.670.3220

STUDENT'S FULL NAME / GRADE

DATE OF BIRTH *(MM/DD/YYYY)*

PERMISSION

Heritage Christian School has my permission to authorize emergency medical treatment for the child identified above and/or take my child to the emergency room of the nearest hospital. I also extend further permission for the physicians and medical staff of the nearest hospital to provide treatment which is deemed necessary by said physicians and medical staff for the physical well-being of my child.

PARENT/LEGAL GUARDIAN NAME | PARENT/LEGAL GUARDIAN SIGNATURE | DATE

MEDICAL DATA

Date of last DPT/Tetanus

Known illnesses / allergies (asthma, epilepsy, bee stings, etc.)

Routine medications taken

PHYSICIAN | PHONE | ALT PHONE

MEDICATIONS

☐ My child is ***not*** allergic to any medications.

☐ My child is allergic to:

No medications will be given to your child without parental consent. Should your child need medication during the day, please submit proper dosages and instructions to the school office.

The school will administer Tylenol or ibuprofen as you indicate below:

☐ I DO ***NOT*** CONSENT TO MY CHILD BEING GIVEN ANY MEDICATIONS.

☐ PLEASE ADMINISTER TYLENOL IBUPROFEN TO MY CHILD AS NEEDED.
(Please circle one)

INSURANCE

NAME OF INSURANCE COMPANY | POLICY NUMBER

SUBSCRIBER'S NAME | EMPLOYER

It is our policy to record all medical incidents or accidents that occur while your child is in our care.

OTHER MEDICAL CONDITIONS

If your child has other known medical conditions, please explain them below.

Include valuable history information, symptoms to look for, preventive measures that we need to take, and what measures you would like for us to take if a situation were to arise (i.e. *seizures, heart/lung problems, etc*.)