Ark City Christian Academy

Emergency Medical Release

P.O. Box 1181 / 901 N. 5th Street
Arkansas City, KS 67005
620-442-0022
schooloffice@accaschool.org

Student Name: _____ Birthdate: _____/_____/_____ Grade: _____

I/we give permission for my child to participate in all school sponsored activities and absolve the school from liability to me or my child because of injury to my child at school or during any school activity.

I/we agree to hold harmless **Ark City Christian Academy, Inc.**, its affiliated organizations, employees, agents, and representatives, including volunteer and other drivers, from any and all claims arising from my child's participation. This release agreement does not apply to claims of intentional (criminal) misconduct or gross negligence by the school, its employees, or volunteers. If such circumstances are proved in a court of law, I/we acknowledge and agree that the school can assume no financial liability beyond its actual liability insurance policy in force.

In case of accident, illness, or other emergency, I/we request that the school contact me. If the school cannot reach a parent/guardian after conscientious effort, I/we give permission for the school staff to call paramedics or any licensed physician or dentist. If a life-threatening emergency exists, I/we give permission for school staff to call paramedics immediately and then contact me/us as soon as possible thereafter. If transportation by ambulance is required, the school may obtain this service. The school does not assume responsibility for the payment of hospital, doctor, or ambulance fees.

I/we the undersigned parent/guardian of the above mentioned minor, authorize and consent to any X-ray examination, anesthetic, medical dental or surgical diagnosis or treatment, and hospital services which, in the best judgment of a licensed physician or dentist licensed by the state, is deemed advisable that may be rendered to said minor under the general, specific, or special consent of an acting agent of the school, the temporary Custodian of the minor, whether such diagnosis or treatment is rendered at the office of any physician or dentist, or at a hospital licensed by the state. We further authorize said physician or dentist to exercise his/their discretion in authorizing the disposal of any severed tissues or member. I/we agree to assume the financial responsibility for expenses incurred as a result of those services being provided. I/we also agree to be financially responsible for emergency medical transportation.

It is understood that this consent is given in advance of any specific diagnosis or treatment being required, but is given to encourage those persons having temporary custody of the minor, and said physician or dentist to exercise his/their best judgment as to the requirements of such diagnosis or medical or dental or surgical treatment.

_____ _____

Father/Guardian's Signature and Date Mother/Guardian's Signature and Date

Name Printed: _____ Name Printed: _____

(If the child lives with both parents, the release must be signed by both parent/guardians.)

Physician: _____ Phone: _____

Dentist: _____ Phone: _____

Health Insurance Carrier: _____ Policy #: _____

Under the name of: _____ Relationship: _____

Allergies (including reactions to medications): _____

Medication being taken: _____

Preferred hospital: _____ Date of last tetanus shot: _____

Student's home phone: _____ Student's home address: _____

Father's work phone: _____ Cell phone: _____

Mother's work phone: _____ Cell phone: _____

In case of emergency, who is your nearest relative or neighbor we should contact if we are unable to contact you at home or work?

Name: _____Relationship: _____ Phone: _____Cell:_____

Revised 02/14