**COOPER CHRISTAIN ACADEMY**

**AUTHORIZATION FOR EMERGENCY MINOR CARE**

**2024-25**

*Complete One Form For Each Student Enrolled In CCA*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Student Last Name: | First Name: | | | Grade: |
| Parent/Responsible Party Full Name (please print): | | | | |
| Address: | | Home Phone: | Health Insurance Company: | |
| Mother’s Work/Cell # (list both if applicable): | | | Policy Holder: | |
| Father’s Work/Cell # (list both if applicable): | | | Policy Number: | |
| Doctor: | | | Doctor Phone #: | |
| Dentist: | | | Dentist Phone #: | |
| **EMERGENCY CONTACTS:** | | | | |
| 1. Name: | | | Phone #: | |
| 2. Name: | | | Phone #: | |

*In case of emergency illness or accident the child is given first aid and the parent are notified. If the parents or the child’s doctor cannot be located, the child will be taken to the nearest Emergency Room. Cooper Christian Academy does not assume responsibility for the payment of hospital, doctor or ambulance fees.*

I / We the undersigned, parent(s) or legal guardian of the minor listed below:

|  |  |
| --- | --- |
|  |  |
| ***(Minor’s Full Name)*** | ***Date of Birth*** |

Do hereby authorize any x-ray exam, anesthetic, dental, medical or surgical diagnosis or treatment by an physician or dentist licensed by the State and hospital service 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 the physician or dentist, or at a hospital licensed by the State. I/We authorize the physician or dentist to call in any necessary consultants at his/her discretion. It is understood that the consent is given in advance of any specific diagnosis or treatment being required, but is given to encourage those persons who have temporary custody of the minor, and said physician or dentist to exercise his/her best judgement as to the requirements of such diagnosis or medical or dental or surgical treatment. This consent shall remain effective for the duration of the student’s enrollment at Cooper Christian Academy during the above referenced school year, unless sooner revoked by written notice to the CCA school office. A new form is required at the beginning of each school year.

|  |  |  |  |
| --- | --- | --- | --- |
|  | YES | NO | If “Yes”, please describe or list: |
| Does the child have any physical defects or handicaps? |  |  |  |
| Has the child had any operations or severe injuries? |  |  |  |
| Does the child suffer from any allergies or illnesses? |  |  |  |
| Is the child on any long-term prescribed medication? |  |  |  |

***I will not hold Cooper Christian Academy financially responsible for the emergency care and/or transportation for my child.***

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |
| ***Signature of Parent or Guardian*** |  | ***Date*** |  | ***Printed Name of Parent of Guardian*** |