SCHOLA 2015/2016

Release Form

Student Name	Circle the medications that may be administered to your student by Schola personnel.	DOB	Please be specific and use the back, if necessary.			
			Allergies	Current Medication	Previous Injuries Serious Illnesses	Health Conditions Learning Disabilities
1	Acetaminophen Ibuprofen Benedryl Sudafed					
2	Acetaminophen Ibuprofen Benedryl Sudafed					
3	Acetaminophen Ibuprofen Benedryl Sudafed					

Address	City	Zip
Parents/Guardians Names	Home Phone	
Fahter's Address if different from above	Father's Work Phone	Father's Cell Phone
Mother's Address if different from above	Mother's Work Phone	Mother's Cell Phone
Emergency Contact to be used if parents are not available	Emergency Contact Phone	Emergency Contact Cell Phone
Family Physician	Physician Phone	Preferred hospital or clinic in case of emergency

Health Insurance Company	Pre-Certification Phone	Policy #	Group #	ID#
Name of Insured	Employer		Employer Phone	

Medical Treatment Authorization and Release of Liability for academic year 20____ / 20_____

I hereby authorize any representative of Schola to render first aid to my child and/or transport him/her to a hospital and/or call an ambulance. I further authorize any representative of Schola, to consent to medical treatment of my child in the event of an emergency (as determined by the representative) when I cannot be reached. This consent is valid and irrevocable for as long as my child is enrolled in Schola. I understand that medical expenses resulting from the above actions are my responsibility. I hereby release Schola representatives as a group and individually, and Providence Presbyterian Church from any and all liability for injuries to my child arising out of my child's participation in Schola activities.

Signature	Date	Print Name