MEDICAL RELEASE OF LIABILITY

Student_____

Parent/Guardian Medical Release:
I hereby authorize Liberty Christian School personnel or authorized parties acting on behalf of the school to administer emergency medical treatment (first aid) to my child if it is deemed necessary and appropriate to preserve or aid the health and/or well being of my child. I further authorize Liberty Christian School personnel or authorized representative's thereof, that should it be deemed necessary and appropriate to secure emergency medical treatment beyond that which can be reasonably administered at the school or a school function, to contact and engage medical personnel qualified to administer necessary and appropriate emergency medical treatment to my child or transport my child to a facility that can administer appropriate medical treatment. In such cases I consent to the treatment of my child by emergency physicians or other professionally licensed health care providers as determined necessary to provide emergency medical care to my child. I understand and agree that I will be financially responsible for any and all expenses incurred in the treatment of my child. I understand that anytime emergency medical care becomes necessary or transportation to a medical care facility is necessary, Liberty Christian School personnel will make every effort to contact me as appropriate and without jeopardizing the care or treatment of the child.
I also understand that accident and medical insurance will be maintained for my child by me during the calendar year.

Parent Signature _____ **Date**_____

Parent Printed Name _____

Emergency Contact and Medical Information for Student

Child's Name	Date of Birth M F Gender
Parent's/Guardian's Name	Parent's/Guardian's Name
Cell Phone # Work Phone # ( ) ( ) Address City, State Zip Code	Cell Phone # Work Phone # ( ) ( ) Address City, State Zip Code

Alternative Emergency Contacts

#1 Emergency Contact: Relationship to student: Cell Phone # Work Phone # ( ) ( )	#2 Emergency Contact: Relationship to student: Cell Phone # Work Phone # ( ) ( )

Medical Information

Hospital/Clinic Preference	
Physician's Name	Physician's Phone Number
Insurance Company	Policy Number
Is there any reason the student cannot participate in normal playground or athletic activities? Yes ❑ No ❑ If yes, please explain:	

Allergies/Special Health Considerations:

Current Medications: (If current medications change during the school year, please contact the school office.)

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