Peoples Baptist Christian Academy

EMERGENCY TREATMENT PERMIT

I / We (name) _____ and (name) _____ of (city) _____, (state) _____, (county) _____, do hereby state that I am / we are the parent(s) or legal guardian(s) of (child's name) _____, a minor, age _____, born on (date) _____/_____/_____, who resides with me / us at:
(address)_____
Street City State Zip Code

I / We authorize a member of Peoples Baptist Christian Academy staff / faculty in the city of Clifton, New Jersey, to consent to any necessary examination, anesthetic, medical diagnosis, surgery or treatment, and / or hospital care to be rendered to the above named minor under the general or special supervision and on the advice of any physician or surgeon licensed to practice medicine in the United States of America. I / We hereby hold harmless Peoples Baptist Christian Academy and its employees and People's Baptist Church and its employees from any liability or other responsibility arising from said actions. I / We understand that I / we as parent(s) / legal guardian(s), together with my / our insurance carrier, are responsible by operation of law. I / We understand that the emergency center will attempt to contact the parent(s) / legal guardian(s) as soon as possible.

_____/____/____ _____/____/____
Signature of Parent / Legal Guardian Date Signature of Parent / Legal Guardian Date

In case of emergency, parent(s) / legal guardian(s) can be reached as follows:
Home Phone Number (_____)_____ Cell phone / Pager (_____)_____
Mother's business _____ Phone (_____)_____
Father's business _____ Phone (_____)_____
Name of family doctor _____ Phone (_____)_____
Name of insurance company _____ Policy / Group # _____
List two nearby relatives or neighbors who will assume temporary care of your child if you cannot be reached:
Name _____ Relationship _____ Phone (_____)_____
Name _____ Relationship _____ Phone (_____)_____

Medical History

Allergies and corresponding medications _____
_____
Tetanus (date of last booster) _____/_____/_____ Chronic or existing diseases or medical problems (diabetes, epilepsy, asthma, etc.)

_____
Medications your child is now taking _____
Can and may your child have the following: Antacid tablets (Tums): Yes___ No___ Regular aspirin: Yes___ No___ Acetaminophen (Tylenol): Yes___ No___

Note: All other medication that the student may need during school hours must be brought to the school nurse or the school office with doctor's instructions (prescription) or parents' / guardians' instructions (non-prescription). The student may not self-administer the doses. Only the nurse or authorized personnel may supervise this.

Activity Permission

I / We the parent(s) / legal guardian(s) of _____, who is enrolled in PBCA, hereby give my / our permission to the authorities of PBCA to take said student on field trips, athletic trips, or any other supervised school activity.

_____/_____/____ _____/_____/_____
Signature of Parent / Legal Guardian Date Signature of Parent / Legal Guardian Date

Note: This permission form expires one year from date signed.