



5412 67<sup>th</sup> Avenue West ● University Place, Washington 98467 ● (253) 564-6276 ● www.heritagecs.net  
DOING ALL FOR THE GLORY OF GOD – 1 CORINTHIANS 10:31

## **MEDICAL EMERGENCY AUTHORIZATION FORM**

TO BE COMPLETED BY PARENTS AND RETURNED TO SCHOOL OFFICE

Name of Student Athlete: \_\_\_\_\_ DOB: \_\_\_\_\_

### **Authorization To Treat And Obtain Medical Care.**

I, the parent or legal guardian of the above-identified student (my “Child”), authorize Heritage Christian School (the “School”) and its agents and designated healthcare providers to administer first aid care and treatment to my Child while at School and any School-related activities or events.

If illness or injury should occur, I authorize the School to obtain emergency treatment (including, but not limited to, medical, dental and hospital care) for my Child. I understand that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required. I also recognize and understand that the School will endeavor consult with me concerning the reasons for, and effects of, all such care prior to obtaining such care. Recognizing that it may be difficult to reach me, I authorize the School to permit commencement of treatment and to execute any necessary documents required prior to treatment, when, in the professional judgment of the treating medical provider, such treatment is deemed medically necessary, even if I have not yet been consulted. In authorizing such emergency treatment, I agree to accept the medical

professional’s determination that the treatment rendered was medically necessary to protect the life, health, or mental well-being of my Child. I acknowledge and agree that I am responsible for any expenses incurred by my Child in obtaining and receiving such treatment.

### **Authorization To Share Health Information.**

I authorize the School to release to, and obtain from, any treating hospital, clinic, licensed medical facility, or attending healthcare provider, my Child’s health information for purposes of diagnosis, treatment, care, or prognosis of any medical problem. I further authorize the School to confer (telephonically, in person, electronically, or otherwise) with such professionals.

I understand and agree that the School consists of a team of faculty members and administrators at the School who collaborate with respect to my Child’s educational experience. As part of this collaborative effort, I understand and agree that the School may share my Child’s health information with other School employees on a “need-to-know” basis, including, without limitation, in cases of health and safety emergencies; when there is concern about my Child’s ability to function academically, emotionally, physically, or mentally within the School environment; or when legal requirements demand that confidential information be revealed.

### **Waiver Of Liability.**

I agree, on my own behalf and that of my Child and our heirs, executors, administrators, personal representatives, and/or assigns (“Releasers”), to forever release, acquit, discharge, covenant to hold harmless and covenant not to sue the School, its trustees, employees, volunteers, representatives, and agents (“Releasees”) from any and all claims, suits, liabilities, and actions, including, but not limited to, any negligence

(but not for willful or wanton conduct) of the Releasees, which Releasors may have, now or in the future, which arise directly or indirectly out of any authorized first aid and emergency treatment of my Child. I further agree, on behalf of myself and my Child, to indemnify and hold harmless the Releasees against any and all demands, claims, suits, actions, causes of action, or liabilities, covered by the above release.

**Medical Providers:** Please provide information for your Child's medical providers.

Name	Address	Phone
<b>Doctor:</b>		
<b>Dentist:</b>		

**Medical Insurance.**

I understand that I am responsible for the costs of medical care for my Child while my Child is enrolled in the School. All students attending Heritage Christian School are recommended to have adequate medical insurance coverage. The School does not assume responsibility for such coverage. Please provide the insurance company and policy number for your Child below.

Insurance Company: \_\_\_\_\_

Group No.: \_\_\_\_\_ ID No.: \_\_\_\_\_

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I have read this form in its entirety and understand what it means. By signing this form, I affirm that I have legal custody of my Child and am authorized to sign on my Child's behalf.

\_\_\_\_\_  
Parent/Guardian Signature #1

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name #1

\_\_\_\_\_  
Phone #1

\_\_\_\_\_  
Parent/Guardian Signature #2

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name #2

\_\_\_\_\_  
Phone #2

**Emergency Contact Person:**

\_\_\_\_\_  
Name

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Relationship