

**MITCHELL ROAD CHRISTIAN ACADEMY  
PARENTAL CONSENT FOR MEDICAL TREATMENT**

This release gives us permission to take your child to the nearest available medical facility and have the necessary treatment administered. This is not necessary from our perspective; however, many hospitals will not administer any medical attention to a minor without some parental consent.

IN CASE OF EMERGENCY, I UNDERSTAND THAT EVERY EFFORT WILL BE MADE TO CONTACT ME. IF I CANNOT BE REACHED, I HEREBY GIVE MITCHELL ROAD CHRISTIAN ACADEMY THE PERMISSION TO ACT IN MY BEHALF IN SEEKING EMERGENCY TREATMENT FOR MY CHILD IN THE EVENT THAT SUCH TREATMENT IS DEEMED NECESSARY BY MITCHELL ROAD CHRISTIAN ACADEMY. I GIVE PERMISSION TO THOSE ADMINISTERING EMERGENCY TREATMENT TO DO SO, USING THOSE MEASURES DEEMED NECESSARY. I ABSOLVE MITCHELL ROAD CHRISTIAN ACADEMY FROM LIABILITY IN ACTING ON MY BEHALF IN THIS REGARD SO LONG AS MITCHELL ROAD CHRISTIAN ACADEMY IS NOT GROSSLY NEGLIGENT.

Name of child \_\_\_\_\_  
(Please print)

Parent's Names:

\_\_\_\_\_

Parent's daytime phone \_\_\_\_\_ Home phone \_\_\_\_\_

If parents are not available, please call person listed below:

Name \_\_\_\_\_ Phone \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Additional comments regarding medical history, allergies, penicillin or drug reactions, etc., which may be needed in any treatment.

\_\_\_\_\_  
\_\_\_\_\_

**\*\*\*THIS FORM MUST BE NOTARIZED WITH A RAISED SEAL\*\*\***

Parent or Guardian's insurance company \_\_\_\_\_

Parent or Guardian's insurance company's address \_\_\_\_\_

Parent or Guardian's policy number \_\_\_\_\_

Signed: \_\_\_\_\_ (parent, legal guardian, or person in loco parentis)

Sworn to and subscribed before me

This \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_\_

\_\_\_\_\_  
Notary Public of South Carolina

My commission expires on \_\_\_\_\_

**COMPLETE BACK OF FORM ALSO**

CHILD'S NAME

<b>LAST:</b>	<b>FIRST:</b>
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<b>AGE:</b>	<b>WEIGHT:</b>
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### Medical Permission Form

**All medications you send with your child must be dropped off at the Middle School office ON TUESDAY MORNING THE DAY BEFORE THE TRIP. Prescription medication must be sent in a prescription bottle with your child's name and dosage, including Nasal Sprays. Please call the nurse who will be going to the retreat if you have any changes from what you put on this form.**

In the event a child becomes ill with fever, vomiting or any other contagious illness, the parent will be called immediately and asked to come and pick up their child.

My child can be given the following non-prescription medication. Please circle all that apply.

Ibuprofen Tylenol Benadryl Maalox II Cough Drops Cough Syrup Swimmer's Ear Solution

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### MEDICATIONS YOU ARE SENDING WITH YOUR CHILD (PRESCRIPTION OR NON-PRESCRIPTION)

Name of Medication & Dosage	Time to be given (Circle all appropriate time(s))				
	Breakfast	Noon	Dinner /Bedtime	As Needed	Reason for Taking this Medication
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### ALLERGIES (Food and/or Med's)

Allergy	Treatment
1.	
2.	
3.	
4.	

Any additional information: \_\_\_\_\_

\_\_\_\_\_