

**Camden Christian Academy**

1245 California Ave. SW, Camden, AR 71701  
Phone 870-836-3716

**Medical History/Release Consent**

Student's Name: \_\_\_\_\_

**Physician to be called in case of an emergency**

Name: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

**List emergency contact, if parents cannot be reached**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_ Cell: ( ) \_\_\_\_\_

**Does your child have a history of any medical problems?** (yes) (no)

If yes, explain: \_\_\_\_\_

Allergies: (medication, food, other) \_\_\_\_\_

**List any medication given on a regular basis:** \_\_\_\_\_

**Is there any reason why your child cannot participate in a full Physical Education program?** (yes) (no) If yes, explain: \_\_\_\_\_

In the event of an emergency occurring while my son/daughter is at school or at a school-sponsored activity, I grant permission for employees of Camden Christian Academy to take whatever action necessary for the health and well-being of my son/daughter, \_\_\_\_\_ . In the event that I cannot be reached, I hereby authorize Camden Christian Academy and/or its employees to give consent for my son/daughter \_\_\_\_\_ , to receive medical treatment.

Parent or Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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

Policy #: \_\_\_\_\_ ID #: \_\_\_\_\_