

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? (no) (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 #: _____