

**2011-2012**  
**MEDICAL AUTHORIZATIONS & INFORMATION**

(Please complete one form per student)

Student Name \_\_\_\_\_ Grade \_\_\_\_\_

Teacher/HR \_\_\_\_\_ Home Phone \_\_\_\_\_

Parent's Name \_\_\_\_\_

Father's Work # \_\_\_\_\_ Cell # \_\_\_\_\_

Mother's Work # \_\_\_\_\_ Cell # \_\_\_\_\_

Local relatives/friends to be called in emergency if parents cannot be reached:

1. \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

2. \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

3. \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Family Doctor \_\_\_\_\_ Phone \_\_\_\_\_

Name of Doctor prescribing medication (if different from above) \_\_\_\_\_

\_\_\_\_\_ Phone \_\_\_\_\_

Medical Condition \_\_\_\_\_

Name of prescription medication \_\_\_\_\_

Instruction for administration of medication \_\_\_\_\_

\_\_\_\_\_

Allergies \_\_\_\_\_

***I hereby authorize Killian Hill Christian School to give and/or obtain emergency medical assistance for my student in the event that I cannot be reached. I also assume full financial responsibility for any such medical service rendered.***

\_\_\_\_\_  
*Parent's Signature*

\_\_\_\_\_  
*Date*

***KHCS may administer \_\_\_\_\_ dosage of Tylenol (initial please \_\_\_\_\_)***

***KHCS may administer \_\_\_\_\_ dosage of Ibuprofen (initial please \_\_\_\_\_)***



Medication given	Date	Time

