VOFCA MEDICAL AUTHORIZATIONS & INFORMATION

(Please complete one form per student)

Student Name _____Grade _____
Teacher_____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_____
Allergies _____
_____

Medical Condition _____
_____

Name of Prescription Medication	Instruction to Administer Medication

☐ ***VOFCA may administer Tylenol as needed (initial please _____) Dosage _____***

I hereby authorize Voices of Faith Christian Academy 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

Date	Time	Medication Given	Given By