EMERGENCY MEDICAL AUTHORIZATION

Science Academy of Chicago Staff has my permission to obtain emergency medical treatment for my child in the event of an emergency, when I cannot be reached or if a delay in reaching my child would be dangerous for him/her.

Students Name:_____
DOB_____

Parent/Guardian's Name _____

Day Time Phone _____ Cell Phone_____

E-mail Address: _____

Parent/Guardian's Name_____

Home Phone _____ Cell Phone _____

E-mail Address_____

My insurance provider_____

Subcriber Name_____

Member ID#_____ Group#_____

My child is taking the following medications and
dosages:_____
_____

My child has the following allergies: _____

I understand that I assume all financial responsibility for any treatment or injuries sustained by my child while he/she is at the Science Academy of Chicago.

Signature of Parent or Guardian: _____Date:_____

Signature of Parent or Guardian: _____ Date:_____

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