Dr. D.D. Brown Christian Academy of Hope

STUDENT EMERGENCY CONTACT INFORMATION

Name: _____
Last First Middle

Address: _____
Street City State Zip

Birthdate: _____ Male: _____ Female: _____
Month Date Year

Name and contact information of three (or more) adults we may call if you are not available:

Name: _____ Phone _____ Relationship _____

Name: _____ Phone _____ Relationship _____

Name: _____ Phone _____ Relationship _____

Name: _____ Phone _____ Relationship _____

I do hereby authorize officials of Dr. D.D. Brown Christian Academy of Hope to contact directly the persons named on this card if the school cannot reach me. I authorize the named physician or his associates to render such treatment as may be deemed necessary in an emergency, for the health of the above mentioned child. In the event that parents or guardians, or other persons named on this card cannot be reached, Dr. D.D. Brown Christian Academy of Hope officials are hereby authorized to take whatever action is deemed necessary in the judgment for the health of the above mentioned child.

I HAVE READ THIS FORM AND AGREE TO THE STATEMENT AS IT IS WRITTEN.

_____ _____
Parent/Guardian Signature Date

_____ _____
Parent/Guardian Signature Date