Permission/Consent/Emergency Contact Form

Five Oaks Adventist Christian School

Family Information

Student(s)		
Mother's Name	Home Phone	Work Phone
Father's Name	Home Phone	Work Phone
Legal Guardian	Home Phone	Work Phone

Medical Information

Student	Physician's Name	Physician's Phone Number
Student	Physician's Name	Physician's Phone Number
Student	Physician's Name	Physician's Phone Number
Student	Physician's Name	Physician's Phone Number
Family Health Insurance Information		Policy Number

Emergency Contact Information The following contacts are to be called in the event of an emergency until someone is reached.

Name	1st number to call	2nd number to call	3rd number to call
Name	1st number to call	2nd number to call	3rd number to call
Name	1st number to call	2nd number to call	3rd number to call
Name	1st number to call	2nd number to call	3rd number to call
Name	1st number to call	2nd number to call	3rd number to call
Name	1st number to call	2nd number to call	3rd number to call

The student(s) named above has my permission to participate fully in all Five Oaks Adventist Christian School programs including, but not limited to, field trips, and physical education activities during the 20__ - 20__ school year.

We, the undersigned parents or legal guardians of the above student(s) do hereby consent to any x-ray, examination, anesthetic, medical or surgical diagnosis or treatment and hospital services that may be rendered. It is understood that reasonable effort will be made to contact the parent/guardian and the doctor listed above before any other physician is called by the school. It is understood that this consent is given in advance of any specific diagnosis or treatment which might be required.

_____ _____

Signature of Parent or Legal Guardian Date

The above information is correct for the 20____ -- 20____ school year. _____
(Parent's/Guardian's Signature)

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