



Tri-State Christian School Authorization To Consent To Medical Treatment

(Please Print)

I (We) _____ and _____

are the parent(s)/legal guardian(s), with legal custody of _____

(Child's Name)

who is the age of _____, and resides with us at:

(Full address)

and who attends _____, give

(Name of school)

our permission for a licensed doctor, physician, or emergency treatment center selected by the school coach/representative to administer the necessary attention and aid *Immediately* to our child should he/she become injured or sick while on or during a school event or trip, and to do so without having to wait until we are contacted. We consent to any x-rays, examinations, anesthetic, medical or surgical diagnosis, treatment and hospital care deemed necessary.

We understand the school coach/representative will endeavor to reach us should the nature of the injury or illness warrant it. However, we will not hold any of the school personnel responsible if efforts to contact me (us) are unsuccessful. During this time we can be reached at:

Home: (address stated above) **Home Phone:** _____ or,

Father's Business Phone: _____, **Address:** _____

Mother's Business Phone: _____, **Address:** _____

Cell Phone(s): _____ or _____

Date: _____, **Father/guardian signature** _____

Date: _____, **Mother/guardian signature** _____

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