



CHAMPIONS for Christ

Emergency Contact Information & Medical Consent Form

Academic Year 2023-2024

Student Name(s) (last, first):

Birthdates:

Address _____

Mom's Name (last, first) _____

Dad's Name (last, first) _____

Home Phone _____

Mom's Cell Phone _____ Mom's Work Phone _____

Dad's Cell Phone _____ Dad's Work Phone _____

**Please put a "check mark" next to Phone above where parent can be reached during CHAMPIONS classes. Does this phone receive text messages? YES _____ NO _____*

Known Medical Conditions (Specify which student matches which condition.)

Allergies (Specify which student matches which allergies.)

Medications (Specify which students matches which medications.)

Family Name _____

Preferred Doctor Name _____ Phone _____

Preferred Dentist Name _____ Phone _____

Preferred Hospital _____

Insurer _____ Phone _____

Member Number _____ Group Number _____

Additional Emergency Contact Person _____

Relation to Student _____

Phone Number(s) _____

MEDICAL CONSENT/RELEASE:

As the parent/legal guardian of the above-named student(s), I hereby give my consent that in my absence, if I cannot be reached by telephone, the above-named minor(s) may be admitted to a hospital or medical facility for diagnosis and treatment in the event of an accidental injury or illness. I request and authorize physicians, dentists, and staff, duly licensed as Doctors of Medicine or Doctors of Dentistry, or other such licensed technicians or nurses, to perform any diagnostic procedures, treatment procedures, operative procedures and x-ray treatment on the above minor, as they deem reasonably necessary. I have not been given a guarantee as to the results of examination or treatment. I also assume responsibility for the payment of any such treatment.

I absolve CHAMPIONS for Christ and its representatives from liability in acting on my behalf. I recognize and acknowledge that there is no accident coverage; nor is there any medical payments coverage available to me in order to compensate me for expenses incurred from deductibles, co-payments, prescription drugs, or medical services not covered through my own health insurance provider(s), for any injury my children or any family member sustains as a result of participation in CHAMPIONS for Christ activities. I agree that any medical coverage that I have will be primary and that I will not seek any contribution from CHAMPIONS for Christ, its insurer, or its facility host for any medical expenses.

Signed _____ Date _____
(Parent or Guardian)