



**MEDICAL AND DENTAL INSURANCE INFORMATION:**

\_\_\_\_\_  
Doctor's Name ( )  
Area Code Phone Number  
Address: \_\_\_\_\_ Zip: \_\_\_\_\_

\_\_\_\_\_  
Dentist's Name ( )  
Area Code Phone Number  
Address: \_\_\_\_\_ Zip: \_\_\_\_\_

\_\_\_\_\_  
Insurance Provider No. 1 ( )  
Area Code Phone Number Policy Number  
Address: \_\_\_\_\_ Zip: \_\_\_\_\_

\_\_\_\_\_  
Insurance Provider No. 2 ( )  
Area Code Phone Number Policy Number  
Address: \_\_\_\_\_ Zip: \_\_\_\_\_

=====  
**If your child(ren) has/have known allergies or chronic health problems, please list the child's/children's name(s) medical problem and medications taken daily.**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**CONSENT FOR MEDICAL TREATMENT IN CASE OF EMERGENCY:**

I understand that all reasonable safety precautions will be taken by the school administration, and that the possibility of an unforeseen hazard does exist. I agree not to hold New Harvest Christian School, Faith Community Church, its leaders, employees and volunteer staff liable for damages, losses, diseases, or injuries incurred by the minor(s) listed on this form.

As the parent or legal guardian I hereby give authorization to NHCS to obtain emergency medical treatment from a duly licensed medical care provider for my child in the event of illness or injury. I consent to any x-ray, anesthetic, medical, surgical, or dental diagnosis or treatment that may be deemed necessary for my minor child. This care may be given under whatever conditions deemed necessary to preserve the life, limb or wellbeing of my dependent.

I understand that all efforts will be made to contact me prior to treatment. In the event I cannot be reached in an emergency, I give permission to the administrators to make the decisions necessary for treatment. I further understand that the doctors, dentists and other providers attending to my child will take all reasonable safety precautions during their care.

Further, as parent or legal guardian, I am responsible for the health care decisions for my minor child and agree that my insurance plan is the primary plan to pay for the dental, medical, or hospital care or treatment that is given to my child. Any policy of the school will be used as the secondary coverage.

Date: \_\_\_\_\_

Date: \_\_\_\_\_

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Signature of Parent or Guardian

**NOTE: There are separate authorization forms (in the school office) that must be completed and signed by you if your child(ren) needs prescribed or non-prescribed medication during school hours. Such medication will be kept in the school office and administered by office personnel for the safety of your child(ren).**

