



GEORGIA PREPARATORY SCHOOL, INC.
Medical Treatment Authorization

Student's Name: _____ Birth Date: _____

Address: _____

Mother/Guardian's Name: _____ Cell Phone: _____

Employer: _____ Work Phone: _____

Father/Guardian's Name: _____ Cell Phone: _____

Employer: _____ Work Phone: _____

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Medical Information

Child's Physician _____ Phone _____

Known Allergies: _____

Current Medications: _____

Special Needs/Conditions _____

Emergency contacts when parents cannot be reached:

Name _____ Phone _____ Relationship: _____

Name _____ Phone _____ Relationship: _____

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Medical Treatment and Transport Authorization

If a student becomes ill or is injured while at school, parents will be notified immediately. In case of serious illness or injury, Emergency Medical Services (EMS/911) will be called for immediate transport to the nearest hospital. As indicated by my signature below, in my absence I authorize Georgia Prep personnel to consent to any emergency treatment on behalf of my child deemed necessary by a licensed medical professional. This shall include but not be limited to examination, anesthesia, medical diagnosis, surgery, and/or hospitalization. I acknowledge that I am responsible for any and all medical costs incurred. I further acknowledge that Georgia Prep shall be held harmless and accepts no liability for the emergency medical treatment of my child. This authorization shall be valid during the _____ school year only. The information provided by me in this authorization form is, to the best of my knowledge, accurate and true.

Parent/Guardian: _____ **Date:** _____