



First Assembly Christian School

154 Warren C. Coleman Blvd.

Concord, NC 28027

FACS does not discriminate based on race, creed, or ethnicity.

Medical Treatment Form

Being the parent or legal guardian of _____, (minor's name printed) I

_____ (Parent's name printed) do consent to any x-ray, anesthetic, medical, surgical, or dental diagnosis or treatment that may be deemed necessary for my child. Further, 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 Academy/Church Staff to make the decisions necessary for treatment. Should there be no Academy/Church Staff available, I give permission to the attending physician to treat my minor child. 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 Academy or organization sponsoring this event will be used as the secondary coverage.

Allergies to food, medication, etc. (If none, so state)

Special Medical Conditions (If none, so state)

Family Physician _____ Phone No. _____
Office Address _____

Parent/Guardian Name _____
(Please Print)

Parent/Guardian Home Address _____
(Street Address)

Home Phone _____ Work Phone _____ Cell Phone _____

Insurance Company _____ Policy/Group # _____

Parent/Guardian Signature _____ Date _____
