

**VERITAS CHRISTIAN SCHOOL
HEALTH CARE AUTHORIZATION FORM**

I, _____, of _____ (address),
City of _____, County of _____, State of _____, am the
_____ (father/mother or legal guardian) of _____,
a minor, who attends Veritas Christian School, in Douglas County, Kansas or participates
in Veritas Christian School's extra curricular activities.

In the event an unsuccessful attempt by authorized school personnel or a Veritas
parent to contact me at _____ (phone number) or to contact _____
(other parent or guardian) at _____ (phone number), I give my consent for:

1. The administration of any treatment deemed necessary by the attending
physician or dentist.
2. The transfer of the minor to _____ (preferred hospital) or any
hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of
two licensed physicians concurring in the necessity for such surgery are obtained prior to
the performance of such surgery.

Date of birth: _____ Grade: _____

Allergies: _____

Medication being taken: _____

Date of last tetanus shot: _____

Physical Impairments: _____

Other pertinent facts to which physician should be alerted: _____

My child has health insurance coverage with:

Name of Provider _____ Policy Number _____

Signature by Parent of Legal Guardian

Dated: _____

The foregoing answers were subscribed and sworn to before me this
_____ day of _____, _____.

My Commission Expires:

Notary Public