



NEW COVENANT
CHRISTIAN ACADEMY

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PO Box 348, 218 College Street
Hardin, KY 42048
270-437-3170

MEDICAL AUTHORIZATION FORM

Should it be necessary for my child to have medical treatment while participating in the Job Shadowing/Internship, I hereby give New Covenant Christian Academy and/or work-site personnel permission to use their best judgment in obtaining medical services for my child, and I give permission to the physician selected to render whatever medical treatment he/she deems necessary and appropriate.

_____ **Yes** _____ **No**

Permission is also granted to release emergency contact/medical history to the attending physician or to work-site personnel if needed.

_____ **Yes** _____ **No**

Student's name _____

Date of birth _____

Address _____

Daytime phone for parent or guardian (_____) _____

Contact other than parent or guardian _____

Relation to student _____ Phone (_____) _____

Family doctor _____ Phone (_____) _____

Preferred hospital _____ Phone (_____) _____

My child requires the following special accommodations due to medical limitations, allergies, disabilities, dietary constraints, or other restrictions:

Signature of Parent/Guardian

Date