Imhotep Academy
667 Fairburn Rd. NW
Atlanta, GA 30331
404-586-9595
Fax: 404-586-9597

MEDICAL AUTHORIZATION

Student's Name: _____ Date of Birth _____
Parent/Guardian _____ Day phone # _____
Evening phone # _____
Person giving consent: _____
Relationship to student: _____
Should _____, suffer an injury or illness while in the care
(Student)
of Imhotep Academy, and the facility is unable to contact me immediately, it shall be authorized to secure such medical attention and care of the child as may be necessary. In the event of a medical emergency, every attempt will be made to contact me as soon as possible once the student's safety has been assured. I shall assume responsibility for payment of services. I also understand I WILL NOT hold Imhotep Academy responsible.

I (we) agree to keep Imhotep informed of changes in telephone numbers, pagers, cell phones, etc., where I can be reached.

Imhotep agrees to keep me informed of any incidents requiring professional medical attention involving my child.

This consent shall be effective from: _____

Child's primary source of health care:

_____ _____
(Primary Physician/Clinic Name) (Telephone #)

_____ _____
(Preferred Hospital) (Health Insurance Provider)

_____ _____
(Group #) (Identification #)

List any known medical conditions (i.e. diabetic, asthmatic, drug allergies, food allergies, etc.)
_____
_____
_____

_____ _____
(Signature of Parent/Legal Guardian) (Date)