Emergency Form

In the event of an emergency and I or my spouse are unable to be reached, I authorize the following responsible persons to pick up my child/children or be contacted for information.

Name: _____ Relationship_____ Phone: _____

Name: _____ Relationship_____ Phone:_____

Name: _____ Relationship_____ Phone:_____

Name: _____ Relationship_____ Phone:_____

Emergency Medical Contacts and Consent for Medical Treatment: In the event I cannot be reached, I , or whoever signs my child in for the day (Authorized Representative to act as an agent for me), give my permission for Kids of Valor Academy (KOVA) to provide basic first aid to my child as appropriate, however, I understand KOVA shall not be required to strictly follow those guidelines when, in its judgment, circumstances may require otherwise. In the event that KOVA, in its sole discretion, believes that my child needs more advanced care, I consent to dental, medical, surgical, and/or hospital care, treatment, and/or procedures to be performed for my child by a licensed dentist, physician, ambulance attendant/emergency medical technician, or other licensed health care provider (collectively, "Health Care Professional.") associated with a licensed treatment facility when deemed necessary or advisable by the Health Care Professional to safeguard my child's health. I waive my right of informed consent to such treatment. I also give my permission for my child to be transported by ambulance to an emergency center for treatment. I certify my child is in excellent health and physical condition and has no medical, psychological, physical or mental condition which has not been disclosed to KOVA on the registration form. My child(ren) does not have any infectious, contagious or communicable diseases.

In the event my child is in need of emergency care, I do not require that the following physician or contacted. The information provided below is for informational purposes only. I consent to my child being taken to the treatment facility recommended by the Health Care Professional attending to my child.

Name of Physician: _____

Office Address: _____

Phone: _____

Parent Signature: _____ Date: _____