Classical Educational Services
The Classical School
Release of Liability & Medical Information Form

STUDENT: _____ DATE: _____

The undersigned represents to **Classical Educational Services** that he/she is the legal guardian and natural parent or the legal guardian of the below named child; and the undersigned does hereby consent to such minor taking part in school activities, with full understanding insofar as such activities will include, but are not limited to, transportation off school property for an overnight field trip, that there is always the risk of injury, loss, death and possible consequent expenses for the medical, diagnostic and curative treatments, and incidental loss and expense, and the undersigned does on behalf of such minor assume the risk of such expense, and does hereby wholly release **Classical Educational Services** and any representative from any responsibility of liability; and waives and claims or causes of action against it or its agents that might arise on account of loss, injury, death of expense occasioned by any sort of accident or any other circumstance involving such child, and agrees to hold harmless **Classical Educational Services** in event any such claim should rise; and does hereby authorize **Classical Educational Services** or its representative or other agents to arrange for and consent to x-ray examinations, anesthetic, dental, medical or surgical diagnosis and treatment, and hold harmless **Classical Educational Services** from any such expenses. The undersigned will reimburse **Classical Educational Services** or furnish payment for any such payment, at his or her own expense.

AUTHORIZATION

I give permission for my son/daughter to participate in **The Classical School** and **Classical Educational Services** activities. ***I have read the above Release of Liability and agree to its provisions.***

_____ _____

Parent and/or Legal Guardian's Signature Parent's Name Printed

Date_____ Relationship to Minor_____

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MEDICAL INFORMATION FORM

(Please notify the school office immediately if these emergency numbers change.)

PHYSICIAN'S NAME_____PHONE NUMBER_____

PLEASE LIST ALLERGIES, DRUG ALLERGIES, CHRONIC ILLNESSES, OR MEDICATIONS TAKEN ON A REGULAR BASIS AND DOSAGE GIVEN

_____

WILL YOUR CHILD REQUIRE MEDICATION DURING SCHOOL HOURS?_____

IF YES, PLEASE LIST TYPE AND DOSAGE

_____

MY CHILD MAY BE GIVEN THE FOLLOWING WHEN NECESSARY: (YES or NO.)

ACETAMINOPHEN (TYLENOL)_____ TUMS_____ BENADRYL_____

IBUPROFEN (ADVIL, MOTRIN, etc.)_____ COLD MEDICINE_____

NAMES OF TWO PERSONS TO CALL IF PARENTS CANNOT BE REACHED IN AN EMERGENCY:

NAME_____ RELATION_____ PHONE _____

NAME_____ RELATION_____ PHONE_____

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In case of accident or serious illness, I request the school to contact me. If the school is unable to reach me, I hereby authorize the school to call the Physician noted above, and follow his or her instructions. If it is impossible to contact the Physician, the school may make whatever arrangements necessary.

Parent's Signature _____ Date: _____