RHEMA WORD
CHRISTIAN ACADEMY

CREATING WORLD CHANGERS

RWCA

AUTHORIZATION TO SECURE MEDICAL TREATMENT

Name of Minor _____ Grade _____

Date of Birth ____ / ____ / _____
MM DD YYYY

Name of Parents/Guardians, guardian, or conservator
_____ M or F

Office Phone _____ Home

Phone _____

Address

_____

Street City

_____

State Zip Code

Parent/Guardian 2 Information

Name _____ M or F

Phone _____

4850 N State Rd 7 Lauderdale Lakes FL, 33319 SUITE 110
954-781-8680 Fax: 754-216-0828
Email: info@rhemaschool.org
WWW.RHEMAWORDCHRISTIANACADEMY.COM

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Friend or Relative who will probably know where to locate the Parents/Guardians in event of temporary absence, that can pick up your child/ren from school.

Name _____

Phone _____

Name _____

Phone _____

I authorize the Principal of Rhema Word Christian Academy or a designated representative to secure any and all emergency medical care and treatment for _____(student's full name) for acute illness suffered, or injury sustained while at school or participating in school-related activities.

Emergency treatment may be secured at a licensed hospital, clinic, or medical facility, or by a licensed physician or dentist with the following exceptions:

_____

_____

_____

☐ I understand that cost of services provided by ambulance, private physician, clinic, hospital, or dentist remain the responsibility of the Parents/Guardians or guardian and will not be assumed by the Principal, the designee, or the RWCA Board of Directors.

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