

Beacon of Hope Christian School
Certified by FLOCS # 24998 & 13395

Photo Release _____ Initials

I give my permissions for my child's photograph or video image to be taken while he/she is enrolled at Beacon of Hope. Such images may be posted in classrooms or other appropriate places within the school, used in school presentations, craft projects or promotional materials, and in the yearbook. I understand that I may terminate this permission at any time in the future by notifying the school office in writing.

Please check and /or list and medical condition your child my have:

_____ Asthma _____ Diabetes _____ Heart Condition _____

Other _____

_____ Allergies Please

specify _____

If allergic, what are signs/symptoms of allergic reaction(s)?

Other Health Condition(s)/Concerns/Medications/Food Sensitivities:

AUTHORIZATIONS FOR EMERGENCY MEDICAL CARE _____ Initials

In order to meet all legal requirements, I hereby authorize the principal of the school, or the person in charge in the event of her absence, to give my consent for any and all necessary emergency medical treatment for my child while said child is in said individual's custody. In the event of serious illness or accident, and I cannot be immediately contacted, I give permission to have my child moved by ambulance or other conveyance to a doctor's office, clinic, or hospital for immediate attention. I also guarantee payment of all charges incurred as a result of this medical treatment.

Health insurance carrier: _____ Policy

AUTHORIZATION TO TRANSPORT _____ Initials

I give my permissions for the transport of my child in the event of an emergency that requires the school to vacate the premises and I and/or my contacts are unreachable, I hereby authorize the principal, or the person in charge in the event of her absence, to transport my child to a safe environment until I can be reached.

Child's Name _____ Date of Birth ____/____/____

Family Physician _____ Office Phone _____

Father's Name _____ Daytime Number _____

Mother's Name _____ Daytime Number _____

Address _____ City _____

(Signature of Legal Parent/Guardian)

(Date)



BHCS Is Fully Accredited Through

