

# NEW HOPE COURSES FOR HOMESCHOOLERS

In the unlikely event that your child is injured or becomes sick at New Hope's Boxford location, during a lab experience, while on a field trip or other activity sponsored by New Hope, or en route to/from these activities, every effort will be made to contact you. Should you be unavailable, and the situation warrants, emergency treatment will be obtained. Depending on the circumstances, your child's physician or dentist identified below will be notified.

## AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

**Please print:**

Student's Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle \_\_\_\_\_

Date and place of birth \_\_\_\_\_ Age \_\_\_\_\_

Home address \_\_\_\_\_  
Street City, State Zip

Mother's Name \_\_\_\_\_ Daytime phone \_\_\_\_\_

Father's Name \_\_\_\_\_ Daytime phone \_\_\_\_\_

Insurance Carrier \_\_\_\_\_ Policy # \_\_\_\_\_

Local person to contact if parent/guardian cannot be reached \_\_\_\_\_

Phone number for the above contact person \_\_\_\_\_

Physician \_\_\_\_\_ Phone \_\_\_\_\_

Dentist \_\_\_\_\_ Phone \_\_\_\_\_

Special instructions \_\_\_\_\_

I also authorize New Hope to dispense the following medications to my child at the child's request:  
\_\_\_ aspirin \_\_\_ ibuprofen \_\_\_ acetaminophen \_\_\_ Benadryl \_\_\_ other \_\_\_\_\_

I HEREBY AUTHORIZE EMERGENCY TREATMENT FOR THE ABOVE NAMED STUDENT, and I have noted any known PRESCRIPTION ALLERGIES on the Allergy Alert Form.

Signature of parent or guardian

Date