The German School of Dallas

Emergency Contacts and Medical Treatment Authorization & Consent Agreement and Disclaimer

Student: _____

Date of Birth (Month/Day/Year):_____ Age: _____

Allergies/Information:_____
Please note additional information we need to know about you and/or your child on the back of this form.

Primary Family Contact (Signer):

Full Name:_____ Relationship to student: _____

Street: _____

City: _____ State:_____ Zip Code: _____

Cell phone: _____ Email: _____

Alternative Family or Emergency Contact:

Full Name:_____ Relationship to student: _____

Street: _____

City: _____ State:_____ Zip Code: _____

Cell phone: _____ Email: _____

Disclaimer:

By registering with The German School of Dallas and signing this form, you agree to the following terms:

I/We, being parent(s) or legal guardian(s) and/or a student myself, hereby acknowledge that The German School of Dallas is not responsible for any bodily injuries while the students attend class or on the church property.

If a child presents a severe discipline problem, the teacher will discuss this with a responsible parent/guardian. If necessary, the school reserves the right to dismiss such a student.

The Medical Treatment Authorization and Consent Agreement is designed for those situations where children and/or minors are unaccompanied by either parents or legal guardians. It gives authority to a designated adult to arrange for medical care for a child and/or minor in the event of an emergency. Medical care cannot be provided to a child and/or minor without approval by the parents or legal guardians, unless you are declaring your consent by submitting this form.

I/We, being parent(s) or legal guardian(s) do hereby authorize a representative of The German School of Dallas or such substitute as he/she may designate as agent of the school to consent to any X-Ray, anesthetic, medical, dental, or surgical diagnosis or treatment and hospital care for the registered student named child and/or minor which is deemed advisable by and to be rendered under the general or special supervision of any physician and/or surgeon, licensed under the Provision of Medicine Practice Act or of any dentist licensed under the Dental Practice Act, whether such diagnosis or treatment is rendered at the office of said physician or dentist, at a hospital, or elsewhere.

I/We accept the Disclaimer and Medical Treatment Authorization & Consent Agreement.

Name (print):_____ Signature:_____ Date: _____