

# Northwest Christian Academy

## 2025-26 LIMITED POWER OF ATTORNEY FOR EMERGENCY MEDICAL CARE

*International Student*

**TO WHOM IT MAY CONCERN:** I  (the parent or legal guardian) hereby give permission that my child,  may be given emergency treatment to include first aid and CPR by a qualified emergency medical or first aid caregiver. I further authorize and consent to medical, surgical and hospital care, treatment and procedures to be performed for my child by a licensed physician or hospital when deemed immediately necessary or advisable by the physician to safeguard my child's health. I waive my right of informed consent to such treatment. I also give permission for my child to be transported by ambulance or aid car to an emergency center for treatment.

**Name:**  **Relationship to child:**

**Signature:**  **Date:**

### Host Family Emergency Numbers:

<input type="text"/>	<input type="text"/>
Name/Relationship	Best Contact Number
<input type="text"/>	<input type="text"/>
Name/Relationship	Best Contact Number
<input type="text"/>	<input type="text"/>
Name/Relationship	Best Contact Number

### Student U.S. Address:

**Student Date of Birth:**

**Insurance Company:**

**Policy/Membership #:**  **Group #:**

**Policy Holder Name:**

### Allergies and/or Important Health Information:

*This form must be completed every school year.*

## 2025-26 HEALTH INFORMATION

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Student Name:

**Please check any of the following symptoms that have been noted:**

- Frequent sore throats     Tires easily     Frequent earaches     Frequent stomach aches  
 Frequent headaches     Poor appetite     Frequent nosebleeds     Shortness of breath  
 Fainting spells     Pain in legs or joints     Other:

**Diseases:** *Please check any of the following that the student has or had.*

- 4 or more colds a year     Measles     Poliomyelitis     Tonsillitis  
 Pneumonia     Ear Infections     Chicken Pox     Diabetes  
 Mumps     Eczema     Heart Disease     Asthma/Hay Fever  
 Hernia (rupture)     Other:

**Please explain: List any operation, injuries or important information:**

Physical Date:

Physician:

Has your child ever been around anyone known to have Tuberculosis?

Are there any remarks regarding your child's health, mental or emotional development you would like to call to our attention?

I state that the above answers to the above questions are correct.

Parent/Guardian Signature

Date: