THE ALEXANDRIA ACADEMY

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Reset Print

Medical Authorization

I, the parent/guardian of _____ give permission for my child to receive emergency medical or surgical treatment and to be hospitalized, if necessary. I understand that every attempt will be made to contact me or the person names as our emergency contact before taking this action. I hereby waive and release The Alexandria Academy and its staff from any liability for any injury or illness incurred while my child participates in activities related to school and extracurricular activities. I will be financially responsible for any medical attention needed.

Parent / Guardian Signature **Date**

Parent / Guardian Signature **Date**

The Alexandria Academy prohibits discrimination against or harassment of any employee, applicant, or student because of race, color, national or ethnic origin, age, religion, disability, sex, sexual orientation, gender identity and expression, veteran status or any other characteristic protected under applicable federal or state law.