ESCHEL
Eastside Christian Home Educators, LTD.

Family Last Name:_____

Address (street):_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Email Address:_____

Father's Name:_____ Work/Cell Phone:_____

Mother's Name:_____ Work/Cell Phone:_____

EMERGENCY MEDICAL INFORMATION

Eastside Christian Home Educators, Ltd. (ESCHEL) has my permission to call an ambulance or '911' to transport my child(ren) to the nearest medical facility for emergency medical treatment. I also give permission for a representative of ESCHEL to authorize any mnedical treatment deemed necessary.

Mother's Signature:_____ Date:_____

Father's Signature:_____ Date:_____

_____

Family Physician's Name Phone

_____

Street Address City State Zip

_____

Hospital Preference (name of hospital) Hospital Phone

_____

Insurance Company Contract No. Group No.

Medical Information (allergies, etc.):