CLASSIC COOKING

MEDICAL AUTHORIZATION FORM

Dear Parent:
In the event that your son/daughter is injured while in attendance in one of our programs, every effort will be made to contact you. In case we are experiencing difficulty in contacting parents/guardians of students during an emergency, the law requires that written permission must be obtained from the parent/guardian before any type of medical treatment can be administered to the student.
We are, therefore, requesting a signed medical authorization form by the parent/guardian to be held on file in our campus office.

Should it be necessary for my child to have medical treatment while participating in the respective cooking class/program, I hereby give the school personnel permission to use their judgment in obtaining medical service for my child. I give permission to the physician selected by the school district personnel to render medical treatment deemed necessary and appropriate by the physician.

Student Name: _____

Class & Date(s) Attending: _____

Date of Birth: _____

Address: _____

Telephone: Home: _____ Work: _____
Mobile: _____

Contact Person Other than Parent/Guardian:
Name: _____ Phone: _____

Relation to Student: _____

Food Allergies and Dietary Restrictions: A 72-hour advance notice must be given to Classic Cooking of any food allergies or dietary restrictions. We cannot guarantee modifications will be made.

Does the child have a dietary restriction or an allergy to any food or medication? Yes ☐
No ☐

If Yes, explain: _____

Does the child have any behavioral conditions that may conflict with the class? Yes ☐
No ☐

If Yes, explain: _____

Parent Name: _____

Parent Signature: _____ Date: _____