



# AIA SUMMER CAMP 2024

## PICK UP AUTHORIZATION / EMERGENCY CONTACTS

The following people are authorized to pick up my child from school. A copy of a valid driver's license will be required of all persons (other than parents) picking up students. Please list these contacts in order of first call preference. These contacts will be called in non-emergency situations or school wide pick-ups when the parents cannot be reached.

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Name	Relationship	Cell phone
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Name	Relationship	Cell phone
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Name	Relationship	Cell phone
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Name	Relationship	Cell phone
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Name	Relationship	Cell phone
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## PHOTOGRAPHY RELEASE

As the parent/guardian of \_\_\_\_\_, I hereby consent to the use of photographs/video taken during the course of the summer camp for publicity, promotional and/or educational purposes (including school website, social media and/or other media sources). I do this with full knowledge and consent and waive all claims for compensation for use.

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Parent/Guardian Signature

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Date



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List any allergies or sensitivities to foods, insects, medicines, etc:

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List any special medical conditions or medication required to treat a special situation:

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If an "EpiPen" or special medication is required, please make sure to complete a Medication Authorization Form and leave it in the office.

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Student's Doctor

Phone

Hospital Preference: \_\_\_\_\_

In the event that my child should need first aid treatment that is not life threatening, I approve the use of the following "over the counter" treatments to be used on my child by any AIA staff member.

Anti Itch    \_\_\_ yes    \_\_\_ no  
Benadryl    \_\_\_ yes    \_\_\_ no  
Neosporin   \_\_\_ yes    \_\_\_ no

Sting Stop        \_\_\_ yes    \_\_\_ no  
Hand Sanitizer    \_\_\_ yes    \_\_\_ no  
Saline Solution    \_\_\_ yes    \_\_\_ no



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## Emergency Medical Treatment

Student's Full Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_  
First Last

Address: \_\_\_\_\_  
Street City State Zip

Parent/Guardian \_\_\_\_\_ Phone # \_\_\_\_\_

Parent/Guardian \_\_\_\_\_ Phone # \_\_\_\_\_

### AUTHORIZATION AND CONSENT FOR MEDICAL TREATMENT (in case parents can't be reached)

I \_\_\_\_\_ Parent/Legal Guardian of \_\_\_\_\_ hereby authorize the bearer, who is a member of the staff of Alpharetta International Academy, to sign on my behalf any and all forms required in order to obtain emergency medical or hospital care for my child, and request that necessary emergency treatment be provided by you for my child. I realize that I am responsible for payment for such emergency care. A photocopy of this document shall have the same force and effect as the original.

\_\_\_\_\_  
Parent Signature and Relationship to Child Date

\_\_\_\_\_  
Parent Signature and Relationship to Child Date