AIA SUMMER CAMP 2026

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

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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.

____
Name Relationship Cell phone

____
Name Relationship Cell phone

____
Name Relationship Cell phone

____
Name Relationship Cell phone

____
Name Relationship Cell phone

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.

______________________________________ ____________________
Parent/Guardian Signature Date

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

____

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

____

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

____

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	Sting Stop	____yes	____no
Benadryl	____ yes	____no	Hand Sanitizer	____yes	____no
Neosporin	____ yes	____no	Saline Solution	____yes	____no