



AIA SUMMER CAMP 2025

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
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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.

Parent/Guardian Signature

Date



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Emergency Medical Treatment

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
Benadryl ___ yes ___ no
Neosporin ___ yes ___ no

Sting Stop ___ yes ___ no
Hand Sanitizer ___ yes ___ no
Saline Solution ___ yes ___ no



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

Student's Full Name: _____ **Date of birth:** _____
First Last

Address: _____
Street City State Zip

Parent/Guardian _____ Phone # _____

Parent/Guardian _____ Phone # _____

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