

AUTHORIZATION TO CONSENT TO MEDICAL TREATMENT

(PLEASE PRINT)

I (We), _____ and _____,

are the parent(s) / legal guardian(s) , with legal custody, of _____ ,

(child's name)

who is _____ and resides with me (us) at: _____

(age)

(full address)

and who attends _____,

(school)

give our permission for a licensed doctor, physician or emergency treatment center selected by the school coach/representative to administer the necessary attention and aid **IMMEDIATELY** to our child should he/she become injured or sick during the **2008-2009** school year and to do so without having to wait until we are contacted. We consent to any X-rays, examinations, anesthetic, medical or surgical diagnosis, treatment and hospital care deemed necessary.

We understand the school coach/representative will endeavor to reach us should the nature of the injury or illness warrant it. However, we will not hold any of the school personnel responsible if efforts to contact us are unsuccessful. During this time, we can be reached at:

HOME: (address stated above) HOME PHONE: (_____) _____, or

FATHER'S BUSINESS: _____

Address: _____ Phone: (_____) _____

MOTHER'S BUSINESS: _____

Address: _____ Phone: (_____) _____

FIELD TRIP AUTHORIZATION: We further give our permission for our student to accompany his/her class on all field trips throughout the school year. If transportation is needed, it will be arranged by the school. Students will always be accompanied by an adult/teacher and will be under adequate supervision. Parents will be notified of any time and place.

Father/guardian: _____ Date: _____

(signature)

Mother/guardian: _____ Date: _____

(signature)

***** OVER FOR MEDICAL INFORMATION *****

Authorization to Consent to Medical Treatment (cont.)

MEDICAL INFORMATION

NEIGHBOR OR CLOSE RELATIVE WHO MAY BE CALLED IF PARENTS CANNOT BE CONTACTED:

1. Name: _____ Phone: (_____) _____

Address: _____ Relationship: _____

2. Name: _____ Phone: (_____) _____

Address: _____ Relationship: _____

Child's Doctor: _____ Phone: (_____) _____

Address: _____

Medical Insurance Company: _____

Policy Number: _____

Allergies to medicines or other allergies: _____

Child is presently taking the following medications: _____

for the following conditions: _____

Additional Information: _____

In the event that my child is tardy or absent to school and I do not contact the school before 8:00 a.m., you may contact me _____
(name of parent or guardian)

at home work: _____
(circle one) (name of employer)

at the following telephone number: _____.
(include area code)