

CONSENT FOR MEDICAL TREATMENT
PART I AND II MUST BE COMPLETED

PART 1: TO GRANT CONSENT

I hereby give consent for the following medical care providers and local hospital to be called.

Physician _____ Phone () _____

Dentist _____ Phone () _____

Medical Specialist _____ Phone () _____

Local Hospital _____ Emergency Room Phone _____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) administration of any treatment deemed necessary by above named doctors, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist, and (2) the transfer of the child to the hospital reasonably accessible.

This authorization does not cover major surgery unless the medical options of two licensed physicians or dentist, concurring in the necessity for such surgery, are obtained to the performance of such surgery

Facts concerning the child's medical history, including allergies, medications taken, and any physical impairment to which a physician should be alerted here.

Date _____ Signature of Parent _____

PART II REFUSAL TO CONSENT

I do NOT give my consent for emergency medical treatment of my child. In the event of illness or injury requiring medical treatment, I wish the school authorities to take the following action :

Date: _____ Signature of Parent/Guardian _____