CONSENT FOR EMERGENCY TREATMENT OF A MINOR CHILD

STUDENT INFORMATION:

Student Name: ____________________

Date of Birth: ____________________

List ALL Medications: ____________________

List Allergies or Medical Conditions: ____________________

Pediatrician/Family Physician: ____________________

Phone Number: ____________________

EMERGENCY CONTACT INFORMATION:

CONTACT IN CASE OF EMERGENCY AND PARENTS/GUARDIAN CANNOT BE REACHED

Name: ____________________

Home Phone: ____________________

Cell Phone: ____________________

Work Phone: ____________________

Address: ____________________

PARENT/GUARDIAN CONSENT

PLEASE PRINT: I, ______________________________ (parent/guardian name), the parent/guardian of ______________________________ (student name), consent to the emergency treatment of my minor child when I am temporarily separated from that child and/or unavailable to authorize medical treatment.

Parent Guardian Signature: ____________________

Date: ____________________

Witness Signature: ____________________

Date: ____________________