

Student Information

Student Name:

Last

First

Middle

Address:

City

State ZIP Code

Home Phone: ()

Alternate Phone:

()

Parent e-mail Address:

Gender

Birth Date:

Grade:

Residential Parent Information

Father's Name:

Work Number

Cell Number

Mother's Name

Work Number

Cell Number

Other Contact:

Work Number

Cell Number

Name of Relative or Childcare Provider

Daytime Phone

()

Address:

Relationship

to student:

Complete EITHER Part I or Part II, but not both.

Part I: TO GRANT CONSENT - I hereby give consent for the following medical care providers and local hospital to be called:

Medical Insurance:

Physician:

Phone:

Dentist:

Phone

Dentist

Phone:

Local Hospital

Phone

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the 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 any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

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

Date

Signature of Parent/Guardian

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 emergency treatment. I wish the school authorities to take the following action:

Date:

Signature of Parent/Guardian