MEDICAL CONSENT AUTHORIZATION

Student's Name _____ Date of Birth _____

Address _____
(street, town, state, zip)

Parent Phone _____ / _____
(home) / (mobile)

Medical Provider Information

Insurance Provider _____ Policy Number _____

Physician _____ Phone _____

Address _____
(street, town, state, zip)

In Case of an Emergency Contact (please provide 2)

Name_____ Phone _____

Relationship _____

Name_____ Phone _____

Relationship _____

Medical Problems and Medications
This information is included to provide information to emergency personnel of medical problems and medications in an emergency situation.

Existing Medical Problem(s)

_____

Medication	Taken Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medical Consent Authorization
In the event of an injury, accident, illness or other emergency, and if I cannot be reached and the above stated physician cannot be reached, I authorize my child to be treated by certified emergency personnel such as emergency medical technicians, emergency room physicians and other emergency room personnel, such as nurses and laboratory technicians. I agree to accept financial responsibility for the costs related to this medical treatment.

Name of Authorized Parent or Guardian _____

Signature _____

Date _____