Consent &
Medical Authorization

School: _____

Activity: _____

Scheduled Date: _____

_____has my permission to attend the activity/event listed on the scheduled date. I understand that the activity/event is a school sponsored event and may result in absence from regularly scheduled classroom time or activities. I understand that if my student must be sent home early for disciplinary reasons, it will be at my expense. The school district representative supervising the activity/event is hereby granted my permission to seek and authorize any medical treatment that may be necessary for the health and well-being of_____in the event of accident or injury while he/she is attending the activity/event listed above for which my permission has been given.

Dated:_____ 20_____

_____

Parent / Guardian (circle one)

Consent of Parents/Guardian – Medical Care & Treatment Form

Student Name:		Date of Birth:
Parents' Names:		
Telephone (Home)	(Work)	(Cell)
Home Address:		
City	State	Zip:
Name of Family Doctor:		Telephone:
Address:		
City	State	Zip:
If you or the doctor cannot be notified, in an emergency notify:		
Name:		Telephone:
Address:		
City	State	Zip:
Health Insurance Company		Telephone:
Address		
City	State	Zip:
Policy Number:		Group Number:

Health Statement

Allergies: (including medications)	Allergic Reaction	Recent Health Problems

Circle any of the following that apply to the student:

Asthma	Allergies	Anaphylaxis	Diabetes	Heart Condition
Seizures	Fainting	Bipolar	Depression	Digestion Issues
Acid Reflux	ADD/ADHD	Hypothyroidism	Hypoglycemia	Migraines
Anxiety	Other:	Other:	Other:	Other:

Comments:

Present Medications	**Dietary Restrictions**
1)	1)
2)	2)
3)	3)
4)	4)