

MEDICAL CONSENT FORM

In case of an accident or illness _____
(Name of student) (Date of Birth)

has my permission to receive emergency care of treatment if deemed necessary.

(Home address, including your city and zip code)

(Home, work & cell phone, including area code)

(Signature of parent)

(Printed name of parent)

Health Insurance Company _____

Group or Account Number _____

(Please attach copy of health insurance card)

Student's Date of Birth _____

Does the student have any existing medical conditions? Yes or No (please circle one)
If you circled yes, please explain further on the reverse side of this form.

Is the student currently using medication? If your answer is yes, please list them here:

Is the student allergic to any medication (s)? _____

Family Doctor _____ () _____
(telephone number including area code)

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