

STUDENT HEALTH INFORMATION AND MEDICAL TREATMENT CONSENT FORM

Student's full name _____ Age _____

Address _____ Phone _____

City _____ Zip _____

Name of parent/guardian _____

Address _____
(if different from student)

City _____ Zip _____

Home Phone _____ Work Phone _____

Other name and phone number to contact in case of emergency _____

Name of medical doctor or clinic _____

Telephone number _____

Medical Insurance Provider _____

Policy Number _____

MEDICAL INFORMATION

List any known illnesses, allergies (including drug allergies and/or dietary restrictions).

Date of last tetanus shot _____

Medication student is presently taking _____

How often _____

Reason _____



List any physical factors, which might affect student's activity or would be necessary for a physician to know when caring for your child.

MEDICAL TREATMENT CONSENT FORM

If any emergency arises, it might be necessary to seek care for your child before staff can contact you. Such care can be provided only if you sign the authorization below. If you choose not to authorize such medical treatment, you must submit a written explanation, stating your reasons for disallowing such treatment.

In case of minor illness or injury, I give my permission for the supervisor or chaperone of my child _____, or myself _____, to administer necessary treatment and/or first aid. I further authorize any licensed doctor or medical facility or trained emergency technician to administer emergency/surgical care.

The undersigned parent/guardian agrees to pay for medical care authorized above and to pay for return transportation to Hastings, Minnesota necessitated by such emergency.

Signature of parent/guardian _____

Date _____

STATE OF MINNESOTA }
 } ss.
 COUNTY OF DAKOTA }

Subscribed, sworn to, and acknowledged before me by _____

_____, on this _____ of _____, 20_____.

Notary Stamp or Seal

 Notary Public