

# Santa Fe Trail USD #434

## Medical Consent for Emergency Treatment



**STUDENT NAME:**

(one student per form)

Date of Birth:

Grade:

Parent/Legal Guardian Name:

Address:

Phone Number:

Second Emergency Contact & Phone Number:

Health Insurance Policy Holder:

Health Insurance Company Name:

Health Insurance Policy Number

Primary Care Physician:

Primary Care Physician Phone Number:

Preferred Hospital:

Current Prescribed and/or over the counter medications:

Chronic or existing disease and/or medical problems:

Date of Last Tetanus Shot:

Special Dietary needs:

Known Drug Allergies:

### Parental Consent Form/Responsibility Clause/Medical Permit

I, the parent and/or legal guardian of above listed child, authorize and consent to urgent and/or emergency medical treatment for my child when deemed necessary by qualified medical personnel. This authorization is given in advance of any specific treatment being required and I wave my right of prior informed consent to such treatment. **This authorization shall remain effective unless revoked in writing by me or by June 30<sup>th</sup> of the current school year.**

Student Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_