

Medical Consent
Elementary

We hereby consent to the treatment of our minor child by a medical physician or medical personnel at any hospital OR temporary treatment by a registered or licensed practical nurse or emergency medical technician until a medical physician can be obtained for any illness or injury to our minor child while on or adjacent to any school grounds of the **Joint School District No. 2**. This consent shall include, but not be limited to, any surgery deemed required or desirable for immediate health and medical treatment of our child. This consent shall be effective only if none of the undersigned can be contacted or found by reasonable diligence at the time of the needed medical treatment. This consent shall terminate as soon as any of the undersigned are contacted, in which case further medical treatment can be done only with the consent of the person contacted. This consent shall be valid unless and until revoked in writing by one of the undersigned.

Parent/Guardian Signature

Today's Date _____

Grade _____ M F

My child may take:

Acetaminophen (Tylenol) Yes No

NAME OF CHILD _____ **Birth Date** _____

Address _____

Home Phone _____ **Cell Phone** _____

Physician _____ **Phone** _____

Father's Employment _____ **Work Phone** _____

Mother's Employment _____ **Work Phone** _____

Student Lives With _____ Mom Dad Guardian

Emergency Contacts:

1. _____ **Relationship** _____ **Phone** _____

2. _____ **Relationship** _____ **Phone** _____

3. _____ **Relationship** _____ **Phone** _____