CONSENT TO TREAT MINOR

IN CASE OF MEDICAL EMERGENCY

PARENTS/GUARDIANS: Please fill in the requested information on this form as completely as possible.
PLEASE PRINT CLEARLY. We need a separate Medical Consent Form for each student.

STUDENT'S NAME: _____ PARENT/S' NAME & PHONE _____

Preferred HOSPITAL: _____ DOCTOR'S NAME & PHONE _____

We, the undersigned parents/guardians of the Student, a minor, consent on behalf of Student to emergency medical procedures, such as x-ray examination, anesthetic, medial or surgical diagnosis or treatment, and other medical services that may be rendered to the Student in case of a medical emergency and under the general or special instructions of (a) _____ M. D., (b) other licensed medical professional, or (c) an emergency medical team that the School may call to administer aid. This consent applies whether the diagnosis or treatment is rendered at the office of said physician, at a licensed hospital, or at the scene of a medical emergency. The School will attempt to contact the Parent/s and Doctor listed above before or at the same time it calls other medical professionals, and will continue efforts to alert the Parent/s.

This consent is given in advance of any specific diagnosis or treatment which might be required and is given to authorize Mayfair Christian School or licensed medical professionals to exercise their best judgment as to the requirements of such diagnosis or treatment until the Parent/s can exercise their own judgment for the Student.

This consent shall remain in continuous effect until revoked in writing and delivered to the Doctor named above or to the school or organization entrusted with the custody of said minor.

We authorize any hospital, physician, or other person who has attended or examined the minor to furnish to the school insurance service, or its representative, any and all information with respect to any illness, medical history, consultation, prescriptions or treatment, and copies of all hospital or medical records. A copy of this authorization shall be considered as effective and valid as the original.

Student Name: _____ Birth Date: _____
Known Allergies: _____

Medical Conditions & Medications: _____

PARENT & EMERGENCY CONTACT INFORMATION

1st Parent Home Phone: _____ Cell #: _____ Work #: _____

2nd Parent Home Phone: _____ Cell #: _____ Work #: _____

OTHER EMERGENCY CONTACTS (In the event either parent cannot be reached)

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Parent/s Signature: _____ Date: _____