MEDICAL TREATMENT CONSENT FORM

Name ____ Date ______________

Address ____
Street City Zip Code

Home Phone ____________________ Emergency Phone ______________ D.O.B. ________

Parent/Guardian Name ____

Parent/Guardian Insurance Company ____

Policy Number (Please include account & benefit group numbers)

____

Parent/Guardian Place of Employment __________________________ Work Phone ___________

I, ________________________________ authorize any designated agent of School City of Mishawaka to obtain treatment for my son or daughter by a physician, hospital, or other health care provider, in the event my son or daughter is injured or becomes ill while in school, engaged in school activities on or off school premises, or while traveling to or from a school activity, if I cannot be contacted promptly for authorization.

____
Parent/Guardian Signature

(Form Revised 1989)