

Student Name: _____

MEDICAL CONSENT FORM

Consent for Medical/Surgical Care/Emergency Treatment & Medical Information

STUDENT'S LEGAL NAME _____

Parent/Guardian Name _____

Signer's relationship to student: Father Mother Other _____

I hereby give our/my consent to George Stone School for the period of 18 months following the date of my signature below, to arrange for routine or emergency medical/dental care and treatment necessary to preserve the health of our/my child.

I acknowledge that I am responsible for all reasonable charges in connection with care and treatment rendered during the period beginning at the date of the signature below and for eighteen months forward.

Parent/Guardian Address

Address _____
City _____
State _____ ZIP _____
Phone _____

Student's Residence

Address _____
City _____
State _____ ZIP _____

Family Physician

Name _____
Address _____
City _____
Phone _____

Pediatrician

Name _____
Address _____
City _____
Phone _____

Health Insurance Carrier

Group No. _____
Agreement No. _____

Student's Allergies

Date of last tetanus _____

IN CASE OF EMERGENCY I CAN BE REACHED AT

Medications student is taking

Signature of Parent/Guardian (Signature remains in effect for 18 months)

 _____

Subscribed and sworn before me this _____ day of _____, 20____.

Stamp/signature of notary: _____