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	**Student's Residence**
Address _____	Address _____
City_____	City _____
State_____ ZIP_____	State _____ ZIP_____
Phone_____	
Family Physician	**Pediatrician**
Name_____	Name _____
Address _____	Address _____
City _____	City _____
Phone _____	Phone _____
Health Insurance Carrier	**Student's Allergies**
_____	_____
Group No. _____	_____
Agreement No. _____	**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:_____