

June 18, 2008

Dear Parent:

As parent or legal guardian of your children, you are the only individuals who can approve medical treatment for your children due to injury or illness. The Doniphan-Trumbull Public Schools would like to have your permission to seek medical attention for your children if warranted during school sponsored activities, **in the event that you cannot be contacted.**

Enclosed is a **CONSENT TO TREAT A MINOR FORM** that the Doniphan-Trumbull Public Schools would like to have on file for each student in grades 7 through 12. Again, the purpose of this form is for you to give the Doniphan-Trumbull Public Schools authorization to seek medical treatment for your child **in the event that you cannot be contacted.** Your authorization not only will give the Doniphan-Trumbull Public Schools permission to seek medical attention, but also to the medical center providing the treatment.

Please complete and return the **CONSENT TO TREAT A MINOR FORM** *by Friday, August 22, 2008.*

If you have any questions concerning this form, please do not hesitate to call me.

Sincerely,

Harlan Ptomey  
Secondary Principal

**CONSENT-TO-TREAT-MINOR AUTHORIZATION**

**Doniphan -Trumbull Jr./Sr. High School**

I (We), the undersigned parents or legal guardians of \_\_\_\_\_, a minor, authorize treatment of my (our) child by a licensed medical physician on staff at any hospital or medical center and/or any hospitalization that is necessary in the case of an accident or illness.

This consent form will remain effective until the last NSAA sanctioned activity for 2008-2009 unless revoked in writing by the undersigned.

CHILD'S NAME \_\_\_\_\_ GRADE \_\_\_\_\_

CHILD'S ADDRESS \_\_\_\_\_

BIRTH DATE \_\_\_\_\_ DATE OF LAST TETANUS \_\_\_\_\_

ALLERGIES TO DRUGS OR FOODS \_\_\_\_\_

SPECIAL MEDICATIONS, BLOOD TYPE, SURGICAL HISTORY, OR OTHER PERTINENT INFORMATION \_\_\_\_\_

FAMILY PHYSICIAN \_\_\_\_\_ PHONE \_\_\_\_\_

FAMILY DENTIST \_\_\_\_\_ PHONE \_\_\_\_\_

INSURANCE COMPANY \_\_\_\_\_ PHONE \_\_\_\_\_

POLICY NUMBER \_\_\_\_\_

LEGAL GUARDIAN'S NAME \_\_\_\_\_  
(Father's First & Last Name) (Mother's First & Last Name)

ADDRESS \_\_\_\_\_

PHONE (home) \_\_\_\_\_ (business) \_\_\_\_\_ (cell) \_\_\_\_\_

EMERGENCY CONTACT \_\_\_\_\_ PHONE \_\_\_\_\_  
(Person to be contacted in case we cannot get a hold of legal guardian)

I (We) understand that this consent authorization is given in advance of any specific diagnosis or hospital care being required in order to provide authority to any hospital or medical center to render any and all diagnosis, treatment, or hospital care deemed advisable by the physician attending the child in case of an accident or injury.

**AUTHORIZATION SIGNATURE**

LEGAL GUARDIAN \_\_\_\_\_ DATE \_\_\_\_\_