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 2011-2012 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) (Work) (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_____