Bruning-Davenport USD
Consent-To-Treat-Minor Authorization
For 7th – 12th Graders

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 and/or any hospitalization that is necessary in case of an accident or illness.

This consent form will remain effective until May 31, 2023, unless revoked in writing by the undersigned.

CHILD'S NAME_____ SS# (Optional)_____

CHILD'S ADDRESS_____

BIRTH DATE_____ GRADE_____

DATE OF LAST TETANUS VACCINE_____

ALLERGIES TO DRUGS OR FOOD_____

SPECIAL MEDICATIONS, BLOOD TYPE, SURGICAL HISTORY, OR OTHER PERTINENT INFORMATION_____
_____

FAMILY PHYSICIAN_____ PHONE_____

FAMILY DENTIST_____ PHONE_____

INSURANCE COMPANY_____

POLICY NUMBER_____

FATHER'S NAME_____ HOME PHONE_____

ADDRESS_____

CELL PHONE_____ BUSINESS PHONE_____

MOTHER'S NAME_____ HOME PHONE_____

CELL PHONE_____ BUSINESS PHONE_____

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 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

Father_____ Date_____

Mother_____ Witness_____