

CONSENT FOR EMERGENCY TREATMENT OF A MINOR CHILD

We, the undersigned, parents of _____, minor, do hereby consent to any x-ray examination, medical or surgical diagnosis or treatment and hospital services that may be rendered to said minor under the general or special instructions of: _____, M.D., whether such diagnosis or treatment is rendered at the office or at the nearest licensed hospital.

It is understood that a conscientious effort will be made to notify me/us before such action is taken, but if it is impossible to locate one of us, the expense of the services will be accepted by me/us. I understand it is my/our responsibility to have all the correct numbers (address and telephone) on file at the school.

CHILD'S PHYSICIAN: _____ PHONE: _____
ADDRESS: _____ CITY: _____

COMPANY WITH WHICH THE CHILD IS INSURED: _____
ADDRESS: _____ CITY: _____
PHONE: _____ POLICY #: _____

MEDICAL PROBLEMS (I.E. DIABETES, EPILEPSY, ETC.): _____

MEDICATIONS: _____

ALLERGIES (TO MEDICATIONS, FOOD, ENVIRONMENT, ETC.): _____

CHILD'S DATE OF BIRTH: _____

I HEREBY AUTHORIZE ANY STAFF MEMBER OF GRANITE BAY MONTESSORI TO SECURE MEDICAL EMERGENCY TREATMENT FROM THE DESIGNATED PHYSICIAN OF OUR CHOICE, EMERGENCY HOSPITAL OR PARAMEDIC SERVICES AS NEEDED.

MOTHER'S SIGNATURE: _____ DAYTIME PHONE: _____
FATHER'S SIGNATURE: _____ DAYTIME PHONE: _____

WITNESS: _____ DATE: _____

NAME AND TELEPHONE NUMBER OF NEAREST RELATIVE:
NAME: _____ RELATIONSHIP: _____
PHONE #: _____