Consent for Medical Treatment

New Prairie United School Corporation
5327 N. Cougar Road
New Carlisle, IN 46552
574-654-7273 or 219-778-2814

I, (We) ____ of
Parent(s) or Legal Guardian(s)

____, do hereby state
Address City State Zip Code

that I am (We are) the parent(s) or legal guardian(s) of ________________________,
Student's name

age ___________, born ______________, who resides with me (us).
Month, day, year

I (We) authorize personnel employed by the New Prairie United School Corporation to consent to any necessary examination, anesthetic, medical diagnosis, surgery or treatment, and/or hospital care to be rendered to the above named minor under the general or special supervision and on the advice of any physician or surgeon licensed to practice medicine in the state of Indiana. This consent shall be valid for the duration of enrollment of the 20___-20___ school year. The signing of this form does not give authorization for the school to bypass all possible attempts at making parental/emergency contact prior to medical treatment. EVERY possible attempt will be made to contact the parent/guardian.

Dated this _________ day of ____________________, __________.
Date Month Year

____________________________ ____________________________
Signature of parent or legal guardian Signature of parent or legal guardian

Family physician ______________________ Office phone ____________________
Medical Insurance Carrier ____
Identification number ____
Member's name ____
Benefit code _______________________ Account number __________________

Medical history (allergies, if any, including medication)

____
____

Medicines your child is currently taking

____
____

Emergency Contact Information	
Name and Relationship	Contact Number
★ Parent(s)/Legal guardian(s) →	
1.	
2.	
3.	

Hospital or emergency medical facility of choice: ______________________