CONSENT FOR EMERGENCY MEDICAL TREATMENT

Student Name: _____ Date of Birth: _____ Sex: _____

Blood Type: _____ School Enrolled: _____ Grade: _____

I/WE AUTHORIZE THE LOCAL A+ AGENT TO OBTAIN EMERGENCY DENTAL AND/OR MEDICAL CARE FOR OUR CHILD. THIS CARE MAY BE GIVEN UNDER WHATEVER CONDITIONS ARE NECESSARY TO PRESERVE THE LIFE, LIMB, OR WELL-BEING OF MY DEPENDENT CHILD.

A+ Agent Name: _____

Date: _____ Parent/Guardian Signature: _____

Date: _____ Parent/Guardian Signature: _____

HOME ADDRESS: _____

HOME TELEPHONE: (_____) _____ MOTHER'S WORK: (_____)_____

FATHER'S WORK: (_____)_____

FAMILY PHYSICIAN: _____ TELEPHONE: (_____) _____

FAMILY DENTIST: _____ TELEPHONE: (_____) _____

FAMILY HEALTH PLAN: _____ ADDRESS: _____

POLICY HOLDER: _____

POLICY HOLDER'S I.D. #: _____ POLICY/GROUP NUMBER: _____

POLICY HOLDER'S DOB: _____

PLEASE ADD ANY FACTS CONCERNING THE CHILD'S MEDICAL HISTORY INCLUDING ALLERGIES, MEDICATION BEING TAKEN, MEDICAL CONDITIONS AND/OR ANY PHYSICAL IMPAIRMENTS TO WHICH A PHYSICIAN SHOULD BE ALERTED AS NOTED BELOW: *(Medications taken at school require an annual medication authorization form completed and on file in the school office)*