PARENT

Central Private School

Consent for Treatment

Name: _____ Home Phone: _____

Home Address: _____ City: _____ State: _____

Family Physician: _____ Phone: _____

List of any Allergies: _____

Required Medication: _____ Blood Type: _____

Name of Insured: _____

Name of Insurance Company: _____

Policy and/or Group Number: _____

Other Special Instructions: _____

_____

_____

In case of an accident or illness, I hereby authorize a representative of Central Private School to use his/her judgment in obtaining immediate medical care.

Date: _____ Signed: _____
Parent/Guardian

(Parents will be notified in case of serious illness or injury as quickly as they can be reached, but this form will make immediate treatment possible.)