

Student: _____

Grade: _____

Birth Date: ____/____/____

**CENTRAL CHRISTIAN SCHOOL
CONSENT FOR TREATMENT OF A MINOR
GRADES K – 5
2009-2010**

This authorizes the administrator or other CCS staff to give consent for medical treatment, including emergency surgery, for our child named at the top of this form, in the event that neither parent/guardian is available at the time such consent for treatment is needed. This consent will be in effect while this person is a student at Central Christian.

Name of Parents or Guardian: _____

Home Address: _____

Home Phone: _____ Work Phone: _____ Father Cell: _____

Mother Cell: _____ Parent Email: _____

Name of Child's Physician: _____ Phone: _____

Drug Allergies: _____

Medications Child is Taking: _____

Date of Last Tetanus Shot: ____/____/____

Do you give permission for your child to be given Tylenol? _____

Other important health information about your child (such as allergies, chronic illness, etc.)

Employer of Parent/Guardian: _____ Phone: _____

Health Insurance Company: _____ ID #: _____

Please give the names of two people who would know how to reach parent or legal guardian in case of an emergency.

Name: _____ Phone: _____

Name: _____ Phone: _____

Parent/Guardian Signature: _____

Date: ____/____/____