

Student: \_\_\_\_\_

Grade: \_\_\_\_\_

Birth Date: \_\_\_/\_\_\_/\_\_\_

**CENTRAL CHRISTIAN SCHOOL  
CONSENT FOR TREATMENT OF A MINOR  
GRADES K – 5  
2010-2011**

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: \_\_\_/\_\_\_/\_\_\_