Consent of Parents/Guardian – Medical Care & Treatment Form

Student Name:		Date of Birth:
Parents' Names:		
Telephone (Home)	(Work)	(Cell)
Home Address:		
City	State	Zip:
Name of Family Doctor:		Telephone:
Address:		
City	State	Zip:
If you or the doctor cannot be notified, in an emergency notify:		
Name:		Telephone:
Address:		
City	State	Zip:
Health Insurance Company		Telephone:
Address		
City	State	Zip:
Policy Number:		Group Number:

Circle any of the following that apply to the student:

Asthma	Allergies	Anaphylaxis	Diabetes	Heart Condition
Seizures	Fainting	Bipolar	Depression	Digestion Issues
Acid Reflux	ADD/ADHD	Hypothyroidism	Hypoglycemia	Migraines
Anxiety	Other:	Other:	Other:	Other:

Please list any prescription medication to be administered on the trip:

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