RETURN **FALL 2017**

HILLSIDE SCHOOL
CONSENT FOR TREATMENT OF A MINOR

(Please type or print clearly in ***BLACK INK***)

STUDENT'S NAME: _____ DATE OF BIRTH:_____

STUDENT'S ADDRESS _____
Street City State Zip

PARENT/GUARDIAN INFO: Father _____ Mother_____

ADDRESS: _____ _____

CITY, STATE, ZIP: _____ _____

PHONE: (H)_____ (W)_____ (H)_____ (W)_____

Emergency Contact Person:_____ Phone: _____

Family Physician:_____ Phone: _____

Address: _____ City, State, Zip: _____

Medical Insurance Carrier: _____ Policy #:_____

Insured Person's Name: _____ Group #: _____

I, _____, as the parent/legal guardian of _____
(**Print** parent's/legal guardian's name) (**Print** child's name)
give my consent for emergency medical and surgical treatment should his/her condition require it during my absence. I understand that Hillside School will make every reasonable attempt to contact me first, time and conditions permitting.

_____ _____
Parent/Legal Guardian Signature Date

PERTINENT MEDICAL INFORMATION:

CURRENT AGE:_____ DATE OF LAST TETANUS SHOT:_____

MEDICAL PROBLEMS (List Below)

_____

_____

_____

ALLERGIES

Medication	Reaction

Foods	Reaction

Other (e.g. Pollen, animal reaction / dander, etc.)

CURRENT MEDICATIONS	DOSAGE	CONDITION	PHYSICIAN

Over The Counter Medication that is permissible for Hillside to administer (Tylenol, Benadryl ointment, etc.)

use back if needed