



# EMERGENCY MEDICAL TREATMENT CONSENT FORM

711 E. Yale Avenue, Denver CO 80210 • Phone: 303-744-1069 • Fax: 303-744-1060

**Student's Full Name:** \_\_\_\_\_ **Grade** \_\_\_\_\_

Student Lives With: \_\_\_\_\_

**Birth date:** (MM/DD/YYYY) \_\_\_\_\_ **Sex:**  Male  Female

**Name of Father/Guardian:** \_\_\_\_\_ **Home Phone:** \_\_\_\_\_

Home Address: \_\_\_\_\_

Father's Business Phone: \_\_\_\_\_ **Cell/Pager:** \_\_\_\_\_

**Name of Mother/Guardian:** \_\_\_\_\_ **Home Phone:** \_\_\_\_\_

Home Address: \_\_\_\_\_

Mother's Business Phone: \_\_\_\_\_ **Cell/Pager:** \_\_\_\_\_

**Alternate Person to Notify:** (neighbor/ nearby relative who will assume temporary care of your child if you can't be reached)

**Name:** \_\_\_\_\_ **Relation:** \_\_\_\_\_

**Home Phone:** \_\_\_\_\_ **Cell Phone:** \_\_\_\_\_ **Other:** \_\_\_\_\_

Home Address: \_\_\_\_\_

**Family Physician:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

Address: \_\_\_\_\_

**Preferred Hospital:** \_\_\_\_\_

**Dentist:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

Address: \_\_\_\_\_

**Any known allergies:** \_\_\_\_\_

**Any other medical conditions** we should be aware of? \_\_\_\_\_

**Medications taken regularly:** \_\_\_\_\_ **Date of last Tetanus shot:** \_\_\_\_\_

**Insurance Company:** \_\_\_\_\_ **Group #** \_\_\_\_\_ **ID #** \_\_\_\_\_

In case of accident or serious illness, if the school is unable to contact me, I hereby authorize the school to take my child to a hospital emergency room for treatment. In the event that an accident occurs or a medical problem arises in which my child must receive immediate treatment while at school or on a school-sponsored trip, I, the undersigned parent or guardian of the above minor, do hereby consent to any X-ray examination, immunization, anesthetic, medical, or surgical diagnosis or treatment and hospital service that may be required to aid the minor under the general or specific instruction of a physician.

It is further understood that this consent is given in advance of any specific diagnosis or treatment that might be required and is given to authorize Mile High Academy or the physician to exercise their best judgment as to the requirements of such diagnosis or treatment.

I hereby authorize any hospital, physician, or other person who has attended or examined the minor to furnish the insurance service, or its representative, any and all information with respect to any illness, medical history, consultation, prescription or treatment, and copies of all hospital or medical records. A copy of this authorization shall be considered as effective and valid as the original.

Parent/Guardian Name (Please Print) \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ **Date** \_\_\_\_\_

Witness Signature \_\_\_\_\_ **Date** \_\_\_\_\_