

## MEDICAL TREATMENT CONSENT FORM

Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_  
Street City Zip

Home Phone \_\_\_\_\_ Emergency Phone \_\_\_\_\_ D.O.B. \_\_\_\_\_

Parent's Name \_\_\_\_\_

Parent's Insurance Company \_\_\_\_\_

Policy Number (Please include account, benefit Group Numbers)

\_\_\_\_\_

Parent's Place of Employment \_\_\_\_\_ Work Phone \_\_\_\_\_

I, \_\_\_\_\_ authorize any designated agent of the School City of Mishawaka to obtain treatment for my son or daughter by a physician, hospital, or other health care provider, in the event my son or daughter is injured or becomes ill while in school, engaged in school activities on or off school premises, or while traveling to or from a school activity, if I cannot be contacted promptly for authorization.

\_\_\_\_\_  
Parent or Guardian