# MEDICAL CONSENT FORM

Student Name: ______________________________ Phone: ______________
Last First MI

Permanent Address: ______________________________________________
Street/Route City State County Zip

School: **PAOLA HIGH SCHOOL** Phone: **913-294-8010**

School Address: **401 ANGELA DRIVE** **Paola** **Kansas** **Miami** **66071**
Street/Route City State County Zip

Permission is hereby granted to the attending physician to proceed with any medical or minor surgical treatment, x-ray examinations and immunizations for the above named student. In the event of serious illness, the need for major surgery, or significant accidental injury, I understand that an attempt will be made by the attending physician to contact me in the most expeditious way possible. If said physician is not able to communicate with me, the treatment necessary for the best interest of the above named student may be given.

In the event that an emergency arises, an effort will be made to contact the parents or guardians as soon as possible. Permission is also granted to the sponsor to provide the needed emergency treatment to the student prior to his admission to the medical facilities.

______________________________ ______________________
**Signature of Parent or Guardian** **Date**

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## Phone numbers where parents can be reached:

**Home #:** ______________________

**Office #:** ______________________ ______________________
**FATHER** **MOTHER**

**Cell #:** ______________________ ______________________
**FATHER** **MOTHER**

Medical Insurance Company Name: ______________________________

Name of Family Physician: ______________________________

Physician Phone Number: ______________________________