MEDICAL CONSENT FORM

USD 368 Paola, KS
Paola High School ~ 401 North Angela Dr.
Paola Middle School ~ 405 North Hospital Dr.
(To be filled out by all students participating in Athletics/Activities)

Student Name: ______________________________ **Student Cell/Provider:** ____________________

Permanent Address: ____

Date of Birth: _____/_____/_____ **Age:**________ **Gender:**________ **Grade:**________ **Height:**________ **Weight:**________

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/school official to provide the needed emergency treatment to the student prior to his admission to the medical facilities.

EMERGENCY INFORMATION

Guardian 1 Full Name: ______________________________ **Phone:** ____________________

Work Phone:____________________ **Email:**______________________________

Address:____

Place of Employment: ____

Guardian 2 Full Name: ______________________________ **Phone:**____________________

Work Phone:____________________ **Email:**______________________________

Address:____

Place of Employment: ____

Emergency Contact
(someone other than parent or guardian)

Name:____________________ **Relationship:**____________________ **Phone:**____________________

Name:____________________ **Relationship:**____________________ **Phone:**____________________

Medical Ins. Company:______________________________ **Policy Number:** ____________________

Family Physician: ______________________________ **Family Physician Phone:** ____________________

Preferred Hospital:____

Medical Conditions: ____

Allergies to Medications: ____

Current Medications: ____

____ ____________________

Signature of Parent or Guardian **Date**