

**Santa Fe Trail School District
USD #434**

Medical Consent for Emergency Treatment

Date: _____

I, _____ the parent or legal guardian of my child,

_____, _____ authorize and
(student name) (date of birth)

Consent to routine and emergency medical treatment for my child when deemed necessary by qualified medical personnel. This authorization is given in advance of any specific treatment being required and I waive my right of prior informed consent to such treatment. **This authorization shall remain effective unless revoked in writing by me or by June 30 of the current school year.**

(Signature of Parent/ Legal Guardian)

(Date Signed)

(Witnessed)

(Date)

Additional Information:

Family Physician: _____
Medical Insurance: _____
Member Name: _____
Account Number: _____

Phone: _____
ID #: _____
Benefit Code: _____

Medical History:

Allergies, if any, including medication: _____

Chronic or existing disease or medical problems: _____

Medicines currently being taken: _____

Emergency Contact Information: _____

This form must be notarized if the student is participating in sports or activities that require an overnight stay.

Notary:

