



Santa Fe Trail School District #434
Medical Consent Form

Date: _____

Grade: _____

Student's Name

Emergency Contact

Parent/Guardian's Name

Emergency Phone Number

Home Address

Family Physician

City, State & Zip Code

Family Physician's Phone Number

Primary Phone Number

Health Insurance Company Name

Secondary Phone Number

Health Insurance Policy Number

Medications Currently Prescribed: _____

Dosage/Frequency: _____ **Date of Birth:** _____

Allergies (Food, Medications, Seasonal, Etc.): _____

Major Surgeries: _____ **Date of last Tetanus Shot:** _____

Acute Chronic Medical Conditions: _____

Physical Conditions that may limit activity: _____

Special Dietary Needs: _____

Parental Consent Form/Responsibility Clause/Medical Permit

I, _____ the parent or legal guardian of my child,
_____ (student name), authorize and consent to urgent and/or
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. **This authorization shall
remain effective unless revoked in writing by me or by June 30th of the current school year.**

Parent/Guardian's Signature

Date

Relationship to student

Student's Signature

Date

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

Notary: State of Kansas, County of Osage. Signed or attested before me on _____ (date)
by _____ (Parent/Guardian Name).

Notary

(seal)