Authorization for Medical Treatment

I, _____
(Parent/Guardian name - please print)

_____ _____ _____ _____
(Street Address) (City) (State) (Zip Code)

_____ _____ _____
(Daytime phone #) (Evening phone #) (Cell phone #)

Do hereby state that I am the parent/guardian having legal custody of:

_____ is a minor child, born on _____.
(Child's name – please print) (Child's date of birth)

If I cannot be reached, I authorize the following persons to authorize medical services for my child:

Colin McEvoy, Principal or Jess White, Counselor, adults who work at Millennium High School, New York, NY

to consent to any X-ray examination, anesthetic, medical or surgical diagnosis or treatment, and hospital care to be rendered to the minor, at a recognized medical facility, under the general or special supervision of a licensed physician or surgeon.

This authorization will expire on 10/06/18

Parent/Guardian Signature: _____ Date: _____

Medical Information

Child's allergies, if any: (medication, insects, food, etc.) _____

Usual Treatment:_____

Existing Medical problems or conditions, if any _____

Medications your child is taking (list schedule on separate form) _____

Child's Doctor _____ Phone Number _____

_____ _____ _____
(Insurance Company) (Group #) (ID #)

Date of last Tetanus shot _____

In case of emergency, please list the name of a parent or guardian we can reach:

Name _____ Relationship to child _____

Daytime phone number _____ Evening phone number _____

If a parent is not available, please contact:

Name _____ Relationship to child _____

Daytime phone number _____ Evening phone number _____